CHAPTER Ins 4000 UNIFORM REPORTING SYSTEM FOR HEALTH CARE CLAIMS DATA SETS

Readopt Ins 4001, effective 7-10-15 (Document #10877), to read as follows:

PART Ins 4001 PURPOSE AND SCOPE

Ins 4001.01 Purpose and Scope. This chapter contains procedures and substantive requirements for the submission of health care data under RSA 420-G:11, II to the New Hampshire Comprehensive Health Information System by insurance companies, third-party payers, third-party administrators, and carriers that provide administrative services for a plan sponsor.

Readopt with amendment Ins 4002 through 4004, effective 7-10-15 (Document #10877), to read as follows:

PART Ins 4002 DEFINITIONS

Ins 4002.01 Definitions. Unless the context indicates otherwise, the following words and phrases shall have the following meanings:

(a) "Address" means street address, post office box numbers, apartment numbers, e-mail addresses, web universal resource locator (URL), and internet protocol (IP) address number.

(b) "Alternative payment arrangements" means those claims considered paid by the carrier or third-party administrator under a capitated services arrangement or a global payment, resulting in zero paid amounts on the claim.

(c) "Blanket health insurance" means that form of accident and health insurance defined under RSA 415:18, I-a that is not "health coverage" under RSA 420-G:2, IX, that does not require individual applications from covered persons, and that does not require a carrier or third-party administrator to furnish each person with a certificate of coverage.

(d) "Capitated services" means services rendered by a provider through a contract in which payment is based upon a fixed dollar amount for each member on a monthly basis.

(e) "Carrier" means any entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services, or to administer on behalf of a third-party payer, and includes an insurance company, a health maintenance organization, a nonprofit health services corporation, a dental benefits administrator, a third-party administrator, or any other entity arranging for or providing health coverage, Medicare Supplemental, and Medicare Advantage plans.

(f) "Commissioner" means the insurance commissioner.

(g) "Dental claims file" means a data file composed of service level remittance information for all adjudicated claims for each billed dental service provided to members, including data for services provided under alternative payment arrangements with zero paid amounts.

(h) "Department (NHID)" means the New Hampshire insurance department.

(i) "Designee" means an entity with which the department or the department of health and human services have entered into an arrangement pursuant to which the entity performs data management and collecting functions and under which the entity is strictly prohibited from using or releasing the information and data obtained in such a capacity for any purposes other than those specified in the agreement.

(j) "Department of Health and Human Services (DHHS)" means the New Hampshire department of health and human services.

(k) "Direct identifier" means any information, other than case or code numbers used to create anonymous or encrypted data, that plainly discloses the identity of an individual as referenced in 45 CFR Part 164.514 (e)(2).

(l) "Encryption" means a method by which the true value of data has been disguised in order to prevent the identification of persons or groups and which does not provide the means for recovering the true value of the data.

(m) “Exchange” means a governmental agency or non-profit entity that meets the applicable standards of 42 U.S.C. section 13031 and makes qualified health plans available to qualified individuals and qualified employers in accordance with federal law.

(n) "Health care claims data" means the set of data files that are filed by carriers and third-party administrators under this chapter consisting of, or derived directly from, member eligibility, medical claims, pharmacy claims, and dental claims files, including a provider file. "Health care claims data" does not include analysis, reports, or studies containing information from health care claims data sets, if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by the department.

(o) "Hospital" means a licensed acute or specialty care institution.

(p) "Insured" means an individual in whose name an insurance policy is issued.

(q) "Medical claims file" means a data file composed of service level remittance information for all adjudicated claims for each billed medical service provided to members, including data for services provided under alternative payment arrangements with zero paid amounts.

(r) "Members" means all individuals, employees, and dependents for which the health carrier or third-party administrator has an obligation to adjudicate, pay, or disburse claim payments. The term includes covered lives. For employer-sponsored group coverage, members include certificate holders and their dependents.

(s) "Member eligibility file" means a data file containing demographic information for each individual member eligible for medical, pharmacy, or dental benefits for one or more days of coverage at any time during the reporting month as well as any retrospective updates that correspond to previously submitted eligibility data. The term also includes benefits attributed and associated effective periods.

(t) “New Hampshire Comprehensive Health Information System (NHCHIS)” means the system established and operated by the department and the department of health and human services or their designee to collect, store, and analyze health care claims data.

(u) "Pharmacy claims file" means a data file composed of service level remittance information from all adjudicated claims for each billed prescription provided to members, including data for services provided under alternative payment arrangements with zero paid amounts.

(v) “Plan ID” means the 14-character HIOS Plan ID, standard component. The full HIOS ID is unique to each fully insured carrier, product, or plan.

(w) "Plan sponsor" means any persons, other than an insurer, who establishes or maintains a plan covering residents of the state of New Hampshire, including plans established or maintained by employers or jointly by one or more employers and one or more employee organizations, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the plan.

(x) "Prepaid amount" means the amount that would have been paid by the health care claims processor for a specific service if the service had not been capitated or otherwise did not result in a transfer of funds.

(y) "Provider" means a health care facility, medical, dental or behavioral health care practitioner, health product manufacturer, health product vendor, or pharmacy.

(z) "Provider file" means a data file listing information about the service providers identified in the medical claims, pharmacy claims, and the dental claims file as servicing billing, prescribing, or primary providers.

(aa) "Release" means to make data or information available for inspection and copying to persons other than the data submitter.

(ab) "Subcontractor" means a vendor or contractor who manages carved out categories of services, including behavioral health services, pharmacy services, or any other subcontractor that processes claims on behalf of a carrier.

(ac) "Subscriber" means the certificate holder who receives coverage from a carrier or third-party administrator as defined in these rules. For employer-sponsored group coverage, the employee or subscriber is considered the certificate holder. For individual coverage, the policyholder is considered the certificate holder. For other types of group coverage, the certificate holder is considered the person who is the principal insured.

(ad) "Third party administrator" means any persons licensed by the department that receives or collects charges, contributions, or premiums for, or adjusts or settles claims for, residents of the state on behalf of a plan sponsor, health care services plan, dental services plan, nonprofit hospital or medical service organization, health maintenance organization, or insurer.

PART Ins 4003 ANNUAL REGISTRATION REQUIREMENT

Ins 4003.01 Annual Registration Requirement.

(a) Each carrier and each third-party administrator shall submit a completed NHCHIS registration form, available at https://nhchis.com/, to the department or its designee by March 15 of every calendar year.

(b) Carriers and third-party administrators shall notify the department or its designee within 30 days of changes to any of the annual NHCHIS registration information.

(c) Carriers and third-party administrators shall notify the department or its designee of any changes to the individual contact information submitted on the NHCHIS registration form as soon as possible, but no later than 30 days after a reassignment occurs.

Ins 4003.02 Contents of NHCHIS Registration Form. The NHCHIS registration form for carriers and third-party administrators submitting data under RSA 420-G:11, II shall contain the fields required under Ins 4009.01.

Ins 4003.03 Submission of NHCHIS Registration Form. Carriers and third-party administrators shall submit the NHCHIS registration form through the NHCHIS website.

PART Ins 4004 FILING SCHEDULES

Ins 4004.01 Filing Schedules.

(a) The deadline for submitting NHCHIS data files shall be determined by the total number of members for whom claims are being paid or processed by each carrier or third-party administrator.

(b) Carriers and third-party administrators that have 10,000 or more New Hampshire members shall submit required NHCHIS files monthly, no later than 30 days after the close of the reporting month.

(c) Carriers and third-party administrators that have fewer than 10,000 New Hampshire members, but do not meet the exclusion criteria in Ins 4005.02, shall submit required NHCHIS files quarterly, no later than 30 days after the end of the reporting quarter.

Ins 4004.02 First-time Filers.

(a) Carriers and third-party administrators that have not previously submitted files to the department or its designee and that have never registered under this rule shall register no later than 30 days after the first applicable requirement to submit data, using the NHCHIS registration form outlined in Ins 4003.02.

(b) First time submitters shall provide test files within 120 days after registration. The test file size shall correspond to the size required for that carrier or third-party administrator as specified in Ins 4004.01 (a).

(c) No later than 150 days after registration, newly-submitting carriers and third-party administrators shall submit files containing the 3 most recent calendar years of data, January through December. Year-to-date information and monthly or quarterly files shall be provided no later than 180 days after registration.

Ins 4004.03 Changes to Data Submitter's Process, Format, or Sources.

(a) Carriers and third-party administrators that change health plan identifiers or implement new data submission platforms through acquisitions, mergers, or reorganization shall be subject to the requirements for first-time submitters.

(b) Carriers and third-party administrators filing under new health plan identifiers or through new production systems shall provide additional documentation pursuant to instructions from the department or its designee to ensure that NHCHIS maintains a continuous record of member enrollment and claims history before and after the changes.

Readopt with amendment Ins 4005.01 and Ins 4005.02, effective 7-10-15 (Document #10877), cited and to read as follows:

PART Ins 4005 REQUIRED FILERS AND EXCLUSIONS

Ins 4005.01 Required Filers and Data Sets.

(a) In accordance with the submission schedule set forth in Ins 4004, each carrier and third-party administrator shall submit to the department or its designee a complete and accurate health care claims data set.

(b) Carriers and third-party administrators shall submit health care claims data for all residents of New Hampshire and for all members who receive services under a policy issued in New Hampshire, as follows:

(1) Any policy that provides coverage to the employees of a New Hampshire employer that has a business location in New Hampshire shall be considered a policy that is issued in New Hampshire;

(2) An out-of-state employer's branch location in New Hampshire shall be considered a New Hampshire employer, and the carrier and third-party administrator shall submit a claims data set for all members who are employed at that branch location; and

(3) Carriers and third-party administrators shall submit health care claims data for New Hampshire state and municipal employees.

(c) When more than one entity is involved in the administration of a policy, data shall be submitted in accordance with the following:

(1) A carrier shall be responsible for submitting the claims data on policies that it has written;

(2) A third-party administrator shall be responsible for submitting claims data on self-insured plans that it administers;

(3) Each carrier and third-party administrator shall submit all health care claims processed by any subcontractor on its behalf, including claims related to pharmacy services, dental services, and behavioral health, mental health, and substance abuse treatment services;

(4) Each carrier and third-party administrator shall ensure that the subcontractor is not submitting duplicate claims to the department or its designee if the subcontractor falls under the definition of a carrier, meets the requirements of this section, and is required to submit data as a separate entity; and

(5) Each carrier and third-party administrator shall ensure that member and subscriber identifiers in any files processed by subcontracts are consistent with member and subscriber identifiers in the medical and pharmacy claims files and the member eligibility files.

(d) Carriers and third-party administrators shall continue to submit claims data for each month in which they meet the criteria and for the 180 days after the month in which the carrier or third-party administrator withdraws or falls below the exclusion criteria listed in Ins 4005.02.

Ins 4005.02 Exclusions from Filing Requirements.

(a) Carriers and third-party administrators shall not be required to submit health care claims data files, HEDIS® data, or CAHPS survey data if they meet the following criteria:

(1) For carriers that do not offer any products on the health insurance exchange for residents of New Hampshire and that did not cover more than 9,999 members in New Hampshire at any point in any medical, pharmacy, or dental coverage class during the prior calendar year; or

(2) For third-party administrators that did not cover more than 9,999 members in New Hampshire at any point in any medical, pharmacy, or dental coverage class during the prior calendar year.

(b) Carriers and third-party administrators shall perform the calculation for (a) above at the entity level, meaning the level at which major governance decisions are made under a senior leadership team, regardless of the number of companies operating under separate corporate divisions. Carriers or third-party administrators experiencing a drop in membership below the de minimis threshold shall submit claims data and any corrections to membership files for a period of 180 days from the point the carrier or third-party administrator meets the de minimis exemption.

(c) Carriers and third-party administrators shall not be required to submit health care claims data about coverage that is not part of a comprehensive medical insurance policy, including the following:

(1) Specific disease;

(2) Accident;

(3) Injury;

(4) Hospital indemnity;

(5) Disability;

(6) Long-term care;

(7) Vision coverage;

(8) Durable medical equipment; or

(9) Blanket health insurance.

Readopt Ins 4005.03, effective 11-17-16 (Document #12044), to read as follows:

Ins 4005.03 Opt-In by Self-Funded Private Employers.

(a) Each third-party administrator or carrier providing claims administration services to any self-funded private employer that maintains a business location in New Hampshire, including a branch location, shall, within 60 days of the effective date of this rule for current clients or, for new or renewing clients, within 30 days of the date its claims administration services are retained or renewed, present to each such self-funded employer a copy of the "NHID Opt-In Form" for purposes of determining whether the employer directs the carrier or third-party administrator to submit its health care claims data pursuant to Ins 4000.

(b) The "NHID Opt-In Form" shall be presented at least once for each contractual period but need not be presented annually if the contractual period exceeds one year.

(c) Health care claims data for each self-funded private employer that directs the submission of its data shall be included as part of the carrier's or third-party administrator's data submission as indicated on the "NHID Opt-In Form" for that employer.

(d) Each carrier and third-party administrator shall provide to the department annually on March 15 an attestation of compliance with this section with respect to all accounts to which this section was applicable during the prior year. The attestation shall include a list of the self-funded private employers to whom the "NHID Opt-In Form" was presented. However, the association of a particular employer with a particular carrier or third-party administrator may be designated as proprietary information which the department shall, if so designated, hold confidential.

(e) A carrier whose submission includes all relevant data under Ins 4000, without regard to whether the data relate to a self-funded private employer, shall not be required to comply with paragraphs (a) through (d).

(f) The types of employers listed in RSA 420-G:11, IV shall not be considered self-funded private employers under this section, and the "NHID Opt-In Form" shall not be presented to any such employer.

(g) If a self-funded private employer chooses to include the health care claims data of its employees in the state's All-Payer Claims Database (APCD), the employer, or its designee, shall:

(1) Complete and sign the "NHID Opt-In Form" (2016); and

(2) Submit the completed form to its claims administrator.

(h) If the employer has questions about NH's APCD or the department's efforts to improve health care cost transparency, the employer may contact the department at 603-271-2261, or requests@ins.nh.gov, or visit http://www.nh.gov/insurance/.

Readopt with amendment Ins 4006 and Ins 4007, effective 7-10-15 (Document #10877), to read as follows:

PART Ins 4006 HEALTH CARE CLAIMS DATA SET FILING

Ins 4006.01 General Requirements.

(a) Carriers and third-party administrators shall comply with all the technical specifications contained in Ins 4009 and shall include all data elements contained in Ins 4010, including required formats, definitions and sources.

(b) Carriers and third-party administrators shall utilize a data transmission tool provided by the department or its designee to assign a unique identification code to each member and subscriber's record in every file, transform direct identifiers, encrypt the files, and securely transmit the files to the department or its designee.

(c) Upon an amendment to this chapter, carriers and third-party administrators shall submit data that conform to the updated specifications no later than 180 days after the effective date of the new version of the rule.

(d) If the department or its designee identifies technical deficiencies in data submitted by a carrier or third-party administrator, the carrier or third-party administrator shall respond to the department within 10 days with a corrective action plan that the department determines will remove the deficiencies.

Ins 4006.02 Subscriber and Member Identification Data Elements.

(a) Carriers and third-party administrators shall:

(1) Provide a unique identification number for each member and subscriber included in the submitted files; and

(2) Maintain that unique identifier for each member and subscriber for the entire period of coverage for that individual by that carrier or third-party administrator.

(b) Subscriber and member identifiers shall be:

(1) Consistent across all files that contain information about the subscriber or member;

(2) Matched across the member eligibility, medical claims, pharmacy, and dental files, as well as behavioral health claims, as applicable, even where the claims are processed by a subcontractor such as a pharmacy benefits manager; and

(3) Consistent with the technical specifications in Ins 4009.02.

Ins 4006.03 Included Records and Data Requirements.

(a) Carriers and third-party administrators shall report health care claims data for all members meeting the criteria set forth in Ins 4005.01 (b).

(b) Records for medical, pharmacy, and dental claims file submissions shall be reported at the visit, service, or prescription level.

(c) Medical, pharmacy, and dental claims files shall contain all of a claim's payment and adjustment activity during the reporting month regardless of the date of service on the claim.

(d) Claims where multiple parties have financial responsibility shall be included with all medical and pharmacy claims file submissions.

(e) Co-payment or co-insurance amounts shall be reported in 2 separate fields in the medical, pharmacy, and dental claims file submissions.

(f) Carriers and third-party administrators shall include records for services provided under alternative payment arrangements with zero paid amounts.

(g) Carriers and third-party administrators shall include records for services provided by out of network providers and services provided after member exceeds benefits with complete patient liability paid.

(h) Carriers and third-party administrators shall include all service lines associated with fully-processed claims that have gone through an accounts payable run and been booked to the health plan ledger in all medical, dental, and pharmacy claims file submissions.

Ins 4006.04 Observation Period for Record Selection.

(a) Carriers and third-party administrators shall submit a member eligibility file that contains data for each member eligible for medical, dental, or pharmacy benefits for one or more dates of coverage at any time during a reporting month as well as any retrospective updates that correspond to previously submitted eligibility data. It shall include benefits, attributes, and associated effective periods.

(b) Carriers and third-party administrators shall include all claims adjudicated during the reporting month for all members in the member eligibility file for that month.

(c) Carriers' and third-party administrators' data submissions shall contain 180 days claims run out for members in all current or previously submitted files.

Ins 4006.05 Health Care Effectiveness Data and Information Set (HEDIS®) Reporting Requirements.

(a) Each carrier that calculates using (HEDIS®) a system of performance measures maintained by the national committee for quality assurance (NCQA), and submits those data to NCQA, shall report those data that pertain to members who receive their benefits under a policy or plan issued in New Hampshire.

(b) The carrier shall submit HEDIS® data to the DHHS or its designee by July 31st of each year as follows:

(1) The carrier shall submit the data utilizing the appropriate NCQA interactive data submission system (IDSS) import template; and

(2) The carrier shall also submit the results via a workbook, generated with results for each HEDIS® measure appearing on its own worksheet.

Ins 4006.06 Consumer Assessment of Health Plans Survey (CAHPS®) Reporting Requirements.

(a) Each carrier that collects CAHPS® data, a survey overseen by the United States Department of Health and Human Services, agency for healthcare research and quality (AHRQ) and used by NCQA as part of HEDIS® reporting, shall report those data that are collected and that pertain to members who receive their benefits under a policy or plan issued in New Hampshire.

(b) The carrier shall submit CAHPS® data to the DHHS or its designee by July 31st of each year, as follows:

(1) The carrier shall submit the NCQA generated survey results reports; and

(2) The carrier shall also submit all results generated via the NCQA CAHPS® analysis program.

PART Ins 4007 DATA STANDARDS COMPLIANCE

Ins 4007.01 Data Standards Compliance.

(a) Carriers and third-party administrators shall submit files that conform to the formats and standards in these rules, including the technical specifications in Ins 4009.

(b) Carrier and third-party administrator files shall be evaluated upon receipt by the department or its designee to assess compliance with the data quality standards in the submission instructions.

(c) Carriers and third-party administrators shall:

(1) Resubmit nonconforming files at the direction of the department or its designee;

(2) Resubmit a corrected and conforming version of the original submission within 10 business days of the rejection notification from the department or its designee; and

(3) Not submit partial replacement files or record specific corrections.

(d) Carriers and third-party administrators shall submit tables and descriptions about all nonconforming and plan-specific codes appearing in the submission. Files with nonconforming and plan-specific codes without such explanatory information shall be rejected.

Readopt Ins 4008, effective 7-10-15 (Document #10877), to read as follows:

PART Ins 4008 WAIVERS

Ins 4008.01 Waiver of Requirement to Submit Specific Data Element.

(a) Upon application of a carrier or third-party administrator, the department shall grant a waiver of the requirement to submit a particular data element required under these rules, upon a showing by the carrier or third-party administrator that:

(1) The data element does not exist on the carrier's or third-party administrator's transaction system;

(2) The data element cannot be derived reliably from other information available on the carrier's or third-party administrator's transaction system; and

(3) The data element does not reflect information necessary to process claims or to conduct business operations in accordance with generally accepted industry standards, such that it should reasonably be available.

(b) A carrier or third-party administrator that has been granted a waiver shall populate that data field in its claims data submissions in the manner specified in the waiver.

Readopt with amendment Ins 4009, effective 7-10-15 (Document #10877), to read as follows:

PART Ins 4009 TECHNICAL SPECIFICATIONS

Ins 4009.01 Subscriber and Member Identification Data Elements.

(a) The following table lists the subscriber and member identifiers that must be identical when reporting information about a subscriber or a member:

Table 1: Matching Requirements for Subscriber/Member Identifiers Across Files				
Data Element Name*	**Subscriber and Member Identifiers**			
	Member Eligibility	**Medical Claims****	**Dental Claims**	**Pharmacy Claims**
Subscriber Social Security Number	ME008	MC007	DC007	PC007
Plan Specific Contract Number	ME009	MC008	DC008	PC008
Member Suffix or Sequence Number	ME010	MC009	DC009	PC009
Member Identification Code	ME011	MC010	DC010	PC010
Subscriber Last Name	ME101	MC101	DC101	PC101
Subscriber First Name	ME102	MC102	DC102	PC102
Subscriber Middle Initial	ME103	MC103	DC103	PC103
Member Last Name	ME104	MC104	DC104	PC104
Member First Name	ME105	MC105	DC105	PC105
Member Middle Initial	ME106	MC106	DC106	PC106
*The NHCHIS preprocessor hashes these data elements as part of the file encryption and transmission process.				
**Also pertains to Behavioral Health.				

(b) The NHCHIS preprocessor application will hash all subscriber and member identification codes and names before data are transmitted to the department's designee. To ensure consistent hashing, subscriber and member identifiers should not be encrypted or hashed on the initial extract loaded into the preprocessor.

(c) If a third-party administrator does not collect the social security numbers for its members, the third-party administrator shall provide the social security number of the subscriber and assign a discrete two digit suffix for each member under the subscriber's contract using the following criteria:

(1) If the subscriber's social security number is not collected by the third-party administrator, the subscriber's certificate or contract number shall be used in its place. This data element is de-identified by the NHCHIS preprocessor application.

(2) The discrete two digit suffix shall also be used with the certificate or contract number. This data element is de-identified by the NHCHIS preprocessor application.

(3) The certificate or contract number with the two digit suffix shall be at least 11, but no more than 30 characters in length. This data element is de-identified by the NHCHIS preprocessor application.

Ins 4009.02 Technical Specifications and Format for File Transfer.

(a) Carriers and third-party administrators shall use the values in the data tables contained in Ins 4010 or the corresponding externally maintained code tables referenced therein, and:

(1) Carriers and third-party administrators shall submit tables and descriptions for all non-conforming and plan-specific codes appearing in the submission; and

(2) The department and DHHS or its designee shall reject files with non-conforming and plan-specific codes if explanatory information is not provided in advance of the data submission.

(b) Carriers and third-party administrators shall report adjustment records with the appropriate positive or negative fields with the medical, pharmacy, and dental file submissions. Negative values shall contain the negative sign before the value. No sign shall appear before a positive value.

(c) When more than one version of a fully-processed claim service line is submitted, each version of a claim service line shall be enumerated sequentially with a higher version number (MC005A) so that the latest version of that service line is the record with the highest version number (MC005A) and the same claim number + line counter. Where a version number is not available, provide the former claim number in data element MC211. Similar requirements apply to the pharmacy claim file.

(d) All service lines associated with fully-processed claims that have gone through an accounts payable run and been booked to the health plan ledger shall be included on medical, pharmacy, and dental claims data submissions. Do not include service lines:

(1) Rejected due to failed edits;

(2) That are duplicates;

(3) That are from an inactive member; or

(4) Claims that are voided for point of sale adjustments.

(e) Subsequent incremental claims submissions shall include all reversal and adjustment or restated versions of previously submitted claim service lines and all new, fully-processed service lines associated with the claim, provided that they have paid dates in the reporting period, and:

(1) Each version of a claim service line shall be enumerated sequentially with a higher line version number (MC005A); and

(2) Reversal versions of a claim service line shall be indicated by a claim status code = '22' (Field MC038).

(f) Capitated service claims, sometimes known as encounter claims, for capitated services shall be reported with all medical and pharmacy file submissions.

(g) If a claim contains service lines that do not contain a payment because their costs are covered on another line of the claim line, such as under a global payment arrangement, those line(s) shall be:

(1) Included in the data submission; and

(2) Clearly indicated by a claim status code = '04' (Field MC038).

(h) Member eligibility data suppliers must provide a data set that contains information on every covered plan member, regardless of whether the member utilized services during the reporting period. One record per member per month per plan is required. For example, if a member is covered as both a subscriber and a dependent on two different policies during the same month, 2 records must be submitted. If a member has 2 contract numbers for 2 different coverage types, 2 member eligibility records must be submitted.

(i) The Provider ID (MP003) is the unique identifier for a single provider. The Provider ID should only occur once in the table. However, in the event the same provider delivered, and was reimbursed for, services rendered from two or more different physical locations, then the provider data file shall contain two separate records for that same provider reflecting each of those physical locations. One record should be provided for each unique physical location.

(j) Carriers and third-party administrators must use the File Submission "Preprocessor" provided by the DHHS and their designee. The preprocessor hashes or de-identifies member and subscriber information before the data leaves the carrier's and third-party administrator's system.

(k) Carriers and third party administrators must report the minimum value for fully insured and self-insured products to support the department's supplemental reporting reviews. The minimum value is defined as the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage. The minimum value measure is outlined in Section 1302 (d)(2)(C) of the Affordable Care Act. Plans may use the HHS MV calculator available at http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html; may apply a safe harbor developed by HHS and the IRS; or may, for nonstandard plans, provide an actuarial certification from a member of the American Academy of Actuaries.

(l) Each member eligibility file and each medical, pharmacy, and dental claims file submission must contain a header record and a trailer record. The header record is the first record of each separate file submission and the trailer record is the last.

(m) All carriers and third-party administrators submitting APCD files shall be provided with code in the form of a pre-processor, which generates the files in the required format and encrypts them prior to submission. The pre-processor code shall be provided to all carriers and third-party administrators as a down load through a password protected portal.

(n) Carriers and third-party administrators may submit APCD files using the following methods:

(1) Secure File Transport Protocol (SFTP) is the preferred method for submitting files. This method requires logging on to the appropriate SFTP site and sending or receiving files using the SFTP client server. This protocol assumes that it is run over a secure channel, that the server has already authenticated the client, and that the identity of the client user is available to the protocol.

(2) The web upload method allows the sending and receiving of files and messages without the installation of additional software. This method requires internet access, a username, and password. It is not the preferred method due to limitations on the size of the files that can be received, but can be utilized if it is the only method available to the healthcare claims processor.

(o) The member eligibility file, medical claims file, pharmacy claims file, dental claims file, and provider file shall be submitted as separate ASCII files, with variable field lengths and pipe delimited, and shall comply with the following standards:

(1) Each record shall be terminated with a carriage return and line feed (ASCII 13, ASCII 10).

(2) All fields shall be filled where applicable.

(3) Text and date fields shall be left blank when not applicable or if a value is not available.

(4) "Blank" means do not supply any value at all between consecutive field delimiters or last field delimiter and line terminator. Numeric fields without a value shall be filled with a single zero.

(5) Only one record per row shall be submitted. No single line item of data shall contain carriage return or line feed characters.

(6) Text fields shall not be padded with leading or trailing spaces or tabs.

(7) Numeric fields:

a. Shall not be padded with leading zeroes;

b. The integer portion of numeric fields shall not be padded with leading zeros;

c. The decimal portion of numeric fields, if required, shall be padded with trailing zeros up to the number of decimal places indicated; and

d. Positive values are assumed and need not be indicated as such. Negative values shall be indicated with a minus sign and shall appear in the left-most position of all numeric fields;

(8) Date fields:

a. Shall be CCYYMMDD,when a value is provided, unless otherwise [~~I~~]***i***ndicated;

b. Shall not be padded with leading or trailing spaces or tabs; and

c. Shall be left blank when not applicable or if a value is not available.

Ins 4009.03 Data Quality Requirements.

(a) A validation process shall be employed to ensure that the format and content of the submitted files are valid and complete. The validation process is primarily composed of three groups of audits, field level audits, quality audits, and post data consolidation reasonableness, longitudinal, and relational audits, as follows:

(1) All transmitted files are first checked to determine if they are in the correct form and have been created using the provided pre-processor. Field level audits are then employed to evaluate field length and type, code values, and the percentage at which the fields are filled;

(2) Quality audits are employed to determine if the data submitted meet a pre-determined level of reasonableness, for example, percent of institutional claims versus percent of professional claims. Default thresholds, which can be rates or ranges, have been established for approximately 200 quality audits; and

(3) After the files are loaded into staging tables, additional audits are run on the consolidated data to identify any global issues that would not be evident during the field and quality level audit process. The reasonableness, longitudinal, and relational audits confirm whether the appropriate and correct amount of data was received for the corresponding membership volume. Examples of these audits include frequency of individual field values, volume reconciliation, and cost or utilization reasonableness.

(b) Default thresholds or rates shall be applied to the field level audits for each element in the eligibility, claims files, and provider file, and for each quality audit. The standard acceptable threshold for field length, field type, and data value audits is 100 percent. However, there are some fields where the acceptable thresholds for data value will be set at less than 100 percent. Individual field completeness thresholds are established for each data element in the eligibility, medical, pharmacy, dental, and provider files and will vary accordingly. All of the pre-determined default thresholds can be individually adjusted if extenuating circumstances arise which may impact the data completeness or content. If a file is processed and rejected for failing to meet the field level or quality audit default thresholds, the healthcare claims processor can request an exemption to the default threshold through a standardized process. Exemptions or adjustments may be granted for data variances that cannot be corrected due to systematic issues.

(c) At least thirty days prior to the initial submission of the files, or whenever the data element content of the files is subsequently altered, each healthcare claims processor must submit a data set for comparison to

the same validation process used for actual submissions. Iterative rounds of testing may be necessary until the files conform to the submission requirements. A test file should contain data covering a period of one month.

(d) Failure to conform to any of the submission requirements shall result in the rejection and return of the applicable data file(s). All rejected and returned files shall be resubmitted in the appropriate, corrected form within 10 days, or the healthcare claims processor may request an exemption to adjust the threshold for the failing field(s). Due to the large amount and complexity of the data processed, it is more efficient to resubmit an entire file rather than to correct data within the file.

Ins 4009.04 External Code Sources.

(a) Countries
American National Standards Institute
http://webstore.ansi.org/SdoInfo.aspx?sdoid=39&source=iso_member_body

(b) States, Zip Codes and Other Areas of the US
U.S. Postal Service
https://www.usps.com/

(c) National Provider Identifiers
National Plan & Provider Enumeration System
https://nppes.cms.hhs.gov/NPPES/

(d) Health Care Provider Taxonomy
National Uniform Claim Committee (NUCC)
http://www.nucc.org

(e) International Classification of Diseases 9 & 10
American Medical Association
http://www.who.int/classifications/icd/en/

(f) HCPCS, CPTs and Modifiers
American Medical Association
http://www.ama-assn.org/

(g) Dental Procedure Codes and Identifiers
American Dental Association
http://www.ada.org/

(h) National Drug Codes and Names
U.S. Food and Drug Administration
http://www.fda.gov/drugs/informationondrugs/ucm142438.htm

(i) Standard Professional Billing Elements
Centers for Medicare and Medicaid Services (Rev. 10/26/12)
http://www.cms.gov/Regulations-and-fGuidance/Guidance/Manuals/downloads/clm104c26.pdf

(j) Standard Facility Billing Elements
National Uniform Billing Committee (NUBC)
http://www.nubc.org/

(k) DRGs, APCs and POA Codes
Centers for Medicare and Medicaid Services

http://www.cms.gov/

(l) Claim Adjustment Reason Codes
Washington Publishing Company
http://www.wpc-edi.com/reference/

Readopt with amendment Ins 4010, effective 7-10-15 (Document #10877), to read as follows:

PART Ins 4010 DATA TABLES

Ins 4010.01 Member Eligibility Data Tables.

(a) Use Table 4010.7 (a) to determine member eligibility file mapping and formatting.

(b) Member File Header Record Layout

Table 4010.01(b) Member File Header Record Layout

Data Element #	Element	Type	Length (decimal places)	Description/Codes/Sources
HD001	Record Type	Text	2	HD
HD002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
HD003	National Plan ID	Text	30	CMS National Plan ID
HD004	Type of File	Text	2	ME Member Eligibility
HD005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
HD006	Period Ending Date	Date	8	End of paid period for claims or end of month covered for eligibility
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

(c) Member File Trailer Record Layout

Table 4010.01(c) Member File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
TR001	Record Type	Text	2	TR
TR002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
TR003	National Plan ID	Text	30	CMS National Plan ID
TR004	Type of File	Text	2	ME Member Eligibility
TR005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
TR006	Period Ending Date	Date	8	End of paid period for claims or beginning of month covered for eligibility
TR007	Extraction Date	Date	8	Date file was created
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file

(d) Member File Detailed Specification

	Table 4010.01(d) Member File Detailed Specification				
Column Position	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
1	ME001	Payer	Text	8	Payer submitting payments NHID Submitter Code
2	ME002	National Plan ID	Text	30	CMS National Plan ID
3	ME003	Insurance Type Code/Product	Text	2	See Table 4010.6 (a) Insurance Type/Product Code-Eligibility File
4	ME004	Start Year	Number	4 (0)	Year for which eligibility is reported in this submission. CCYY format
5	ME005	Start Month	Number	2 (0)	Month for which eligibility is reported in this submission. MM format. Leading zero is required for reporting January through September files
6	ME006	Insured Group or Policy Number	Text	50	Group or policy number (not the number that uniquely identifies the subscriber)
7	ME007	Coverage Level Code	Text	3	Benefit Coverage Level
					CHD Children Only

	Table 4010.01(d) Member File Detailed Specification				
Column Position	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
					DEP Dependents Only
					ECH Employee and Children
					EMP Employee Only
					ESP Employee and Spouse
					FAM Family
					IND Individual
					SPC Spouse and Children
					SPO Spouse Only
8	ME008	Subscriber Social Security Number	Text	9	Subscriber's social security number. Do not include dashes. Leave blank if not available.
9	ME009	Plan Specific Contract Number	Text	50	Plan assigned contract number. Leave blank if Plan Specific Contract Number is subscriber's social security number. If this is a Medicaid member, provide Medicaid ID
10	ME010	Member Suffix or Sequence Number	Text	20	Uniquely identifies the member within the contract
11	ME011	Member Social Security Number	Text	9	Member's social security number. Do not include dashes. Leave blank if not available.
12	ME012	Individual Relationship Code	Text	2	See Table 4010.6 (b) Relationship Codes
13	ME013	Member Gender	Text	1	M Male
					F Female
					U Unknown
					O Other
14	ME014	Member Date of Birth	Date	8	Date of birth of member
15	ME015	Member City Name	Text	30	City name of member

	Table 4010.01(d) Member File Detailed Specification				
Column Position	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
16	ME016	Member State or Province	Text	2	As defined by the US Postal Service
17	ME017	Member ZIP Code	Text	9	ZIP Code of member – may include non- US codes. Do not include dash.
18	ME018	Medical Coverage	Text	1	Y Yes
					N No
19	ME019	Prescription Drug Coverage	Text	1	Y Yes, member has prescription drug coverage in the period defined with this payer
					N No, member does not have prescription drug coverage in the period defined with this payer
20	ME020	Dental Coverage	Text	1	Y Yes, member has dental coverage in the period defined with this payer
					N No, member does not have dental coverage in the period defined with this payer
21	ME021	Race 1	Text	6	See Table 4010.6 (c) Race 1/Race 2
22	ME022	Race 2	Text	6	See Table 4010.6 (c) Race 1/Race 2
23	ME023	Placeholder			
24	ME024	Hispanic Indicator	Text	1	Y Yes, member is Hispanic/Latino/Spanish
					N No, member is not Hispanic/Latino/Spanish
					U Unknown
25	ME025	Ethnicity 1	Text	6	See Table 4010.6 (d): Ethnicity 1/ Ethnicity 2
26	ME026	Ethnicity 2	Text	6	See Table 4010.6 (d): Ethnicity 1/ Ethnicity 2
27	ME027	Placeholder		20	
28	ME028	Primary Insurance Indicator	Text	1	Y Yes, this is the member's primary insurance
					N No, this is not the member's primary insurance
29	ME029	Coverage Type	Text	3	ASW Self-funded plans that are administered by a third party administrator, where the employer has purchased stop-loss, or group excess insurance coverage

	Table 4010.01(d) Member File Detailed Specification				
Column Position	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
					ASO Self-funded plans that are administered by a third party administrator, where the employer has not purchased stop-loss, or group excess insurance coverage
					STN Short-term non-renewable health insurance, as defined pursuant to RSA 415:5 III
					MCD Medicaid
					MCR Medicare
					UND Plans underwritten by the carrier
					OTH Any other plan. Carriers and third-party administrators using this code shall obtain prior approval from the N.H. Insurance Department
30	ME030	Market Category	Text	4	Three or four digit character code for identifying market category. Employer size is based on the number of eligible employees in the group as define in INS 4100, (INS 4103.03 (g) for the Small Group market, INS 4104.03 (i) for the Large Group market)
					IND Policies sold and issued directly to individuals, other than those sold on a franchise basis, as defined pursuant to RSA 415:19, or as group conversion Policies as defined pursuant to RSA 415:18 VII (a)
					FCH Policies sold and issued directly to individuals on a franchise basis as defined pursuant to RSA 415:19
					GCV Policies sold and issued directly to individuals as group conversion Policies as required pursuant to RSA 415:18 VII (a)
					GS1 Policies sold and issued directly to employers having exactly one employee
					GS2 Policies sold and issued directly to employers having between 2 and 9 employees
					GS3 Policies sold and issued directly to employers having between 10 and 25 employees
					GS4 Policies sold and issued directly to employers having between 26 and 50 employees
					GLG1 Policies sold and issued directly to employers having between 51 and 99 employees

	Table 4010.01(d) Member File Detailed Specification				
Column Position	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
					GLG2 Policies sold and issued directly to employers having 100 or more employees
					GSA Policies sold and issued directly to small employers through a qualified association trust
					OTH Policies sold to other types of entities. Carriers and third-party administrators using this market code shall obtain prior approval from the NH Insurance Department
					BLC Policies sold and issued as blanket health insurance Policies to a common carrier
					BLE Policies sold and issued as blanket health insurance Policies to an employer
					BLV Policies sold and issued as blanket health insurance Policies to a volunteer fire department, first aid, or other such volunteer group
					BLS Policies sold and issued as blanket health insurance Policies to a sports team or a camp
					BLT Policies sold and issued as blanket health insurance Policies to a travel agency, or other organization that provides travel-related services
					BLU Policies sold and issued as blanket health insurance Policies to a university or college
					SLG Policies sold and issued as student major medical expense large group coverage to enrolled students at an accredited college, university, or other educational institution
					STS Policies sold and issued as group short term student health insurance
					SMG Policies sold and issued as student major medical group health insurance
					SNM Policies sold and issued as student group health insurance that is not major medical coverage
					SIM Policies sold and issued as student individual major medical health insurance
					SIN Policies sold and issued as student individual health insurance that is not major medical coverage

	Table 4010.01(d) Member File Detailed Specification				
Column Position	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
31	ME031	NH Health Protection Program	Text	60	For enrollees in the New Hampshire Health Protection Program (NHHPP), indicate if enrollee is part of the Premium Assistance Program (PAP) or Health Insurance Premium Payment (HIPP). Leave blank if enrollee is not a member of the NHHPP
32	ME032	Group Name	Text	4	Name of the group that the member is covered by. If the member is part of a group of one or non-group, indicate I
33	ME101	Subscriber Last Name	Text	60	
34	ME102	Subscriber First Name	Text	35	
35	ME103	Subscriber Middle Initial	Text	1	
36	ME104	Member Last Name	Text	60	
37	ME105	Member First Name	Text	35	
38	ME106	Member Middle Initial	Text	1	
39		Placeholder			
40	ME203	Member's Assigned PCP	Text	20	National Provider ID of the member's Primary Care Physician as designated by healthcare claims processor.
41	ME204	HIOS Plan ID	Text	16	The 16 character HIOS Plan ID (Standard component). Including a five digit issuer ID, two character state ID, three digit product number, four digit standard component number and two digit variant component ID. This field may not be available for all market segments;
42	ME205	Plan Effective Date	Date	8	For the plan reported in ME204, report the date eligibility started for this member under this plan type. The purpose of this data element is to maintain an eligibility span for each member.

	Table 4010.01(d) Member File Detailed Specification				
Column Position	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
43	ME206	Minimum Value	Number	3 (0)	For the plan reported in ME204, report the Minimum Value as described in Part Ins4009.03 (j). This is reported as a percentage.
44	ME207	Exchange Indicator	Text	1	The plan reported in ME204 was available on the Exchange Marketplace in the month and year reflected in ME004 and ME005
					Y Yes
					N No
45	ME208	High deductible health plan	Text	1	The plan reported in ME204 meets the IRS definition of a HDHP
					Y Yes
					N No
					U Unknown
46	ME209	Active enrollment	Text	1	The plan reported in ME204 was open for enrollment in the year and month reflected in ME004 and ME005
					Y Yes
					N No
47	ME210	New Coverage	Text	1	The plan reported in ME204 was being offered for the first time in the reporting year reflected in ME004
					Y Yes
					N No
48	ME211	Placeholder			
49	ME899	Record Type	Text	2	ME
50	ME900	Plan State	Text	2	State in which the plan is sold or used. State codes are maintained by the US Postal Service
51	ME901	Advanced Premium Tax Credit	Number	2(2)	Dollar value of Advanced Premium Tax Credit (APTC) subsidy
52	ME902	NAIC Number	Text	5	Number that the National Association of Insurance Commissioners (NAIC) assigns to each individual underwriting company
53	ME903	Grandfather Plan indicator	Text	1	Indicates if a plan qualifies as a “Grandfathered” or “Transitional Plan” under the Affordable Care Act (ACA). Please see definition for “grandfathered” and “transitional” in HHS rules 45-CFR-147.140: https://www.federalregister.gov/select- citation/2013/06/03/45-CFR-147.

	Table 4010.01(d) Member File Detailed Specification				
Column Position	**Data Element #**	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
					The values of the indicator are as follows: 1= Grandfathered; 2 = Non-Grandfathered; 3 =Transitional; 4 = Not Applicable
54	ME904	Metal Level	Text	10	The metal representation of the plan reported in ME204 on the Exchange Marketplace

Ins 4010.02 Member Claims Data Tables.

(a) Medical Eligibility File Mapping and Format Information. Use Table 4010.7 (b) to determine medical eligibility file mapping and formatting.

(b) Medical Claims File Header Record Layout

Table 4010.02 (b) Medical Claims File Header Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
HD001	Record Type	Text	2	HD
HD002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
HD003	National Plan ID	Text	30	CMS National Plan ID
HD004	Type of File	Text	2	MC Medical Claims
HD005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
HD006	Period Ending Date	Date	8	End of paid period for claims or end of month covered for eligibility
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

(c) Medical Claims Files Trailer Record Layout

Table 4010.02 (c) Medical Claims File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places**	**Description/Codes/Sources**

Table 4010.02 (c) Medical Claims File Trailer Record Layout				
TR001	Record Type	Text	2	TR
TR002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
TR003	National Plan ID	Text	30	CMS National Plan ID
TR004	Type of File	Text	2	MC Medical Claims
TR005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
TR006	Period Ending Date	Date	8	End of paid period for claims or beginning of month covered for eligibility
TR007	Extraction Date	Date	8	Date file was created
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file

(d) Medical Claims File Detailed Specifications

Table 4010.02 (d) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MC001	Payer	Text	8	Payer submitting payments NHID Submitter Code
MC002	National Plan ID	Text	30	CMS National Plan ID
MC003	Insurance Type/Product Code	Text	2	As established by X12 Accredited Standards Committee available at https://ushik.ahrq.gov/ViewItemDetails?system=sdo&itemKey=133161000
MC004	Payer Claim Control Number	Text	35	Must apply to the entire claim and be unique within the payer's system
MC005	Line Counter	Text	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim
MC005A	Version Number	Number	4 (0)	Version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line
MC006	Insured Group or Policy Number	Text	50	Group or policy number (not the number that uniquely identifies the subscriber)

Table 4010.02 (d) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MC007	Subscriber Social Security Number	Text	9	Subscriber's social security number. Do not include dashes. Leave blank if not available.
MC008	Plan Specific Contract Number	Text	50	Plan assigned contract number. Leave blank if Plan Specific Contract Number is subscriber's social security number. If this is a Medicaid claim, provide Medicaid ID.
MC009	Member Suffix or Sequence Number	Text	20	Uniquely identifies the member within the contract
MC010	Member Social Security Number	Text	9	Member's social security number. Do not include dashes. Leave blank if not available.
MC011	Individual Relationship Code	Text	2	See Table 4010.6 (b) Relationship Codes
MC012	Member Gender	Text	1	M Male
				F Female
				U Unknown
				O Other
MC013	Member Date of Birth	Date	8	Date of birth of member
MC014	Member City Name	Text	30	City name of member
MC015	Member State or Province	Text	2	As defined by the US Postal Service
MC016	Member ZIP Code	Text	9	ZIP Code of member – may include non- US codes. Do not include dash.
MC017	Paid Date (AP Date)	Date	8	
MC018	Admission Date	Date	8	Required for all inpatient claims.
MC019	Admission Hour	Text	2 (0)	Required for all inpatient claims. Time is expressed in military time – HH
MC020	Admission Type	Text	1	Required for all inpatient claims (SOURCE: National Uniform Billing Data Element Specifications):
				1 = Emergency
				2 = Urgent
				3 = Elective
				4 = Newborn
				5 = Trauma Center

Table 4010.02 (d) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				9 = Information not available
MC021	Admission Source	Text	1	See Table 4010.6 (i) Point of Origin Codes
MC022	Discharge Hour	Text	2 (0)	Required for all inpatient claims. Time is expressed in military time – HH
MC023	Discharge Status	Text	2	See Table 4010.6 (f): Discharge Status
MC024	Service Provider Number	Text	30	Payer assigned servicing provider number by the payer for internal identification purposes
MC025	Service Provider Tax ID Number	Text	10	Federal taxpayer's identification number – if the tax id is a provider's social security number, use 'SSN' and 'NA' if unavailable
MC026	National Service Provider ID	Text	20	Provider NPI
MC027	Service Provider Entity Type Qualifier	Text	1	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as "Person".
				1 Person
				2 Non-Person Entity
MC028	Service Provider First Name	Text	35	Individual first name. Leave blank if provider is a facility or organization
MC029	Service Provider Middle Name	Text	25	Individual middle name or initial. Leave blank if provider is a facility or organization
MC030	Servicing Provider Last Name or Organization Name	Text	60	Report the name of the organization or last name of the individual provider. MC027 determines if this is an organization or Individual Name reported here.
MC031	Service Provider Suffix	Text	10	Suffix to individual name. Leave blank if provider is a facility or organization. Should be used to capture the generation of the individual clinician (e.g., Jr. Sr., III), if applicable, rather than the clinician's degree [e.g., 'MD', 'LICSW'].
MC032	Service Provider Specialty	Text	10	National Uniform Claims Committee (NUCC) standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of nurses, assistants and laboratory technicians, where applicable, as well as Physicians, Medical Groups, Facilities, etc.

Table 4010.02 (d) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MC033	Service Provider City Name	Text	30	City name of rendering provider - practice location
MC034	Service Provider State	Text	2	As defined by the US Postal Service
MC035	Service Provider ZIP Code	Text	9	ZIP Code of provider - may include non-US codes.
MC036	Type of Bill – Institutional	Text	3	For facility claims only submitted using UB04 forms Type of Facility - First Digit
				1 Hospital
				2 Skilled Nursing
				3 Home Health
				4 Christian Science Hospital
				5 Christian Science Extended Care
				6 Intermediate Care
				7 Clinic
				8 Special Facility
				Bill Classification - Second Digit if First Digit = 1-6
				1 Inpatient (Including Medicare Part A)
				2 Inpatient (Medicare Part B Only)
				3 Outpatient
				4 Other (for hospital referenced diagnostic services
				or home health not under a plan of treatment)
				5 Nursing Facility Level I
				6 Nursing Facility Level II
				7 Intermediate Care - Level III Nursing Facility
				8 Swing Beds
				Bill Classification - Second Digit if First Digit = 7
				1 Rural Health

Table 4010.02 (d) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				2 Hospital Based or Independent Renal Dialysis Center
				3 Free Standing Outpatient Rehabilitation Facility (ORF)
				5 Comprehensive Outpatient Rehabilitation Facility (ORF)
				6 Community Mental Health Center
				9 Other
				Bill Classification – Second Digit if First Digit = 8
				1 Hospice (Non Hospital Based
				2 Hospice (Hospital-Based)
				3 Ambulatory Surgery Center
				4 Free Standing Birthing Center
				9 Other
				Frequency – Third Digit
				0 Non-Payment/Zero
				1 Admit Through Discharge
				2 Interim – First Claim
				3 Interim - Continuing Claims
				4 – Interim – Last Claim
				5 – Late Charge Only
				7 – Replacement of Prior Claim
				8 – Void/Cancel of a Prior Claim
				9 – Final Claim for a Home Health PPS Episode
MC037	Place of Service – Professional*)*	Text	2	For professional claims only, such as those submitted using CMS1500 forms See Table 4010.6 (g) Place of Service -- Professional
MC038	Service Line Status	Text	2	Describes the payment status of the specific service line record
				01 Processed as primary
				02 Processed as secondary
				03 Processed as tertiary
				04 Denied
				06 Approved as amended
				19 Processed as primary, forwarded to additional payer(s)

Table 4010.02 (d) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				20 Processed as secondary, forwarded to additional payer(s)
				21 Processed as tertiary, forwarded to additional payer(s)
				22 Reversal of previous payment
				26 Documentation Claim – No Payment Associated
				28 Repriced
MC039	Admitting Diagnosis	Text	7	ICD-CM Diagnosis Codes. Required on all inpatient admission claims and encounters. Do not include decimals.
MC040	E-Code	Text	7	ICD-CM Diagnosis Codes. Describes an injury, poisoning or adverse effect ICD-CM.
MC041	Principal Diagnosis	Text	7	ICD-CM Diagnosis Codes. Principal Diagnosis should be the principal diagnosis given on the claim header. Do not include decimals.
MC042	Other Diagnosis -1	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC043	Other Diagnosis -2	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC044	Other Diagnosis -3	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC045	Other Diagnosis -4	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC046	Other Diagnosis -5	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC047	Other Diagnosis -6	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC048	Other Diagnosis -7	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC049	Other Diagnosis -8	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC050	Other Diagnosis -9	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC051	Other Diagnosis -10	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.

Table 4010.02 (d) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MC052	Other Diagnosis -11	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC053	Other Diagnosis -12	Text	7	ICD-CM Diagnosis Codes. Do not include decimals.
MC054	Revenue Code	Text	4	National Uniform Billing Committee Codes. Code using leading zeroes, left-justified, and four digits.
MC055	Procedure Code	Text	5	Health Care Common Procedural Coding System (HCPCS). This includes the CPT codes of the American Medical Association
MC056	Procedure Modifier – 1	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
MC057	Procedure Modifier – 2	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
MC058	ICD-9-CM Procedure Code	Text	4	Primary ICD-9/10-CM code given on the claim header.
MC059	Date of Service – From	Date	8	First date of service for this service line.
MC060	Date of Service – Thru	Date	12	Last date of service for this service line
MC061	Quantity	Number	12 (0)	Count of services performed.
MC062	Charge Amount	Number	10 (2)	The full, undiscounted total and service-specific charges billed by the provider.
MC063	Paid Amount	Number	10 (2)	Includes any withhold amounts.
MC064	Fee for Service Equivalent	Number	10 (2)	For capitated services, the fee for service equivalent amount.
MC065	Copay Amount	Number	10 (2)	The preset, fixed dollar amount for which the individual is responsible.
MC066	Coinsurance Amount	Number	10 (2)	Coinsurance , dollar amount
MC067	Deductible Amount	Number	10 (2)	Amount in dollars met by the patient/family in a deductible plan
MC068	Patient Account/Control Number	Text	20	
MC069	Discharge Date	Date	8	Required for all inpatient(s)

Table 4010.02 (d) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MC070	Service Provider Country Name	Text	30	
MC071	DRG	Text	7	Carriers and third-party administrators shall code using the CMS methodology when available. Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the All Payer DRG system is available, then that system shall be used. If the All Payer DRG system is used, the carrier shall format the DRG and the complexity level within the same field with an "A" prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX)
MC072	DRG Version	Text	2	This element is the version number of the grouper used.
MC073	APC	Text	4	Carriers and third-party administrators shall code using CMS methodology. Precedence shall be given to APCs transmitted from the health care provider
MC074	APC Version	Text	2	This element is the version number of the grouper used
MC075	Drug Code	Text	11	NDC Code Used only when a medication is paid for as part of a medical claim.
MC076	Billing Provider Number	Text	30	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes and does not routinely change
MC077	National Billing Provider Number ID	Text	30	This is the NPI for the billing provider
MC078	Billing Provider Organization or Last Name	Text	60	
MC101	Subscriber Last Name	Text	60	
MC102	Subscriber First Name	Text	35	
MC103	Subscriber Middle Initial	Text	1	
MC104	Member Last Name	Text	60	
MC105	Member First Name	Text	35	

Table 4010.02 (d) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MC106	Member Middle Initial	Text	1	
MC200	ICD Indicator	Text	1	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10.
				0 ICD-9
				1 ICD-10
MC202	Other ICD-CM Procedure Code - 2	Text	7	ICD Secondary Procedure Code
MC203	Other ICD-CM Procedure Code - 3	Text	7	ICD Secondary Procedure Code
MC204	Other ICD-CM Procedure Code - 4	Text	7	ICD Secondary Procedure Code
MC205	Other ICD-CM Procedure Code - 5	Text	7	ICD Secondary Procedure Code
MC206	Other ICD-CM Procedure Code - 6	Text	7	ICD Secondary Procedure Code
MC207	Carrier Associated with Claim	Text	8	For each claim, the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
MC208	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	Text	128	When a TPA processes claims on behalf of the carrier, for each claim, report the carrier specific contract number or subscriber/member social security number. Optional if all medical claims processed by a TPA under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
MC209	Practitioner Group Practice	Text	60	Name of group practice to which a practitioner is affiliated if different from MC078
MC210	Coordination of Benefits/Third Party Liability Amount	Number	10 (2)	Coordination of Benefits (COB)/Third Party Liability (TPL) is the dollar amount paid from a prior payer (e.g. auto claim, workers comp, dual medical coverage). Report 0 if there is no COB/TPL amount.
MC211	Cross Reference Claims ID	Text	35	The original Payer Claim Control Number (MC004). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (MC005A) is not used.

Table 4010.02 (d) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MC212	Allowed Amount	Number	10 (2)	Report the maximum dollar amount contractually allowed and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider.
MC215	Service Line Type	Text	1	Report the code that defines the claim line status in terms of adjudication
				O Original
				V Void
				R Replacement
				B Back Out
				A Amendment
MC216	Payment Arrangement Type	Text	1	Defines the contracted payment methodology for this claim line
				1 Capitation
				2 Fee for service
				3 Percent of charges
				4 DRG
				5 Pay for Performance
				6 Global Payment
				7 Other
				8 Bundled payment
MC217	Pay for Performance Flag	Text	1	Does this provider have pay-for-performance bonuses or year-end withhold returns based on performance for at least one service performed by this provider within the month? Required when MP005 = 1, 2, or 3
				Y Yes
				N No
MC218	Claim Processing Level Indicator	Text	1	1 Claim Level
				2 Service Line level
MC219	Denied Claim Indicator	Text	1	1 Fully Paid – the entire claim was paid at the allowed amount

Table 4010.02 (d) Medical Claims File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				2 Partially denied – some of the claims lines were paid at the allowed amount
				3 Encounter claim – this claim records a service provided that is paid under a non Fee For Service (FFS) payment arrangement such as capitation
				4 No payment – no payment made for reasons other than non FFS payment arrangement
MC220	Denial Reason	Text	15	Denial reason code. Required when denied claim indicator = 2 or 4 http://www.wpc-edi.com/reference/
MC221	Procedure Modifier – 3	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
MC222	Procedure Modifier – 4		2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
MC223	HIOS Plan ID	Text	16	The 16 character HIOS Plan ID (Standard component), including a 5 digit issuer ID, 2 character state ID, 3 digit product number, 4 digit standard component number, and 2 digit variant component ID. This field may not be available for all market segments. Leave blank if not available
MC899	Record Type	Text	2	MC
MC900	In Network Indicator	Text	1	A yes/no indicator that specifies that the provider (not the benefit) is within the health plan network. Valid codes: Y=Yes, N=No
MC901	Unit of Measure	Text	2	Type of units reported in MC061. Codes accepted DA=days, MN=minutes, UN=units. If MC061 is not reported, MC[~~225~~]***901***=NA

Ins 4010.03 Pharmacy Claims Data Tables.

(a) Pharmacy Claims Mapping and Format Information. Use Table 4010.7 (c) to determine pharmacy claims file mapping and formatting.

(b) Pharmacy Claims File Header Record Layout

Table 4010.03(b) Pharmacy Claims File Header Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places**	**Description/Codes/Sources**
HD001	Record Type	Text	2	HD
HD002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
HD003	National Plan ID	Text	30	CMS National Plan ID
HD004	Type of File	Text	2	PC Pharmacy Claims
HD005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
HD006	Period Ending Date	Date	8	End of paid period for claims or end of month covered for eligibility
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

(c) Pharmacy Claims File Trailer Record Layout

Table 4010.03 (c) Pharmacy Claims File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
TR001	Record Type	Text	2	TR
TR002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
TR003	National Plan ID	Text	30	CMS National Plan ID
TR004	Type of File	Text	2	PC Pharmacy Claims
TR005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
TR006	Period Ending Date	Date	8	End of paid period for claims or beginning of month covered for eligibility
TR007	Extraction Date	Date	8	Date file was created
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file

(d) Pharmacy Claims Detailed File Specifications

Table 4010.03 (d) Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
PC001	Payer	Text	8	Payer submitting payments NHID Submitter Code
PC002	Plan ID	Text	30	CMS National Plan ID
PC003	Insurance Type/Product Code	Text	2	As established by X12 Accredited Standards Committee, available at https://ushik.ahrq.gov/ViewItemDetails?system=sdo&itemKey=133161000
PC004	Payer Claim Control Number	Text	35	Must apply to the entire claim and be unique within the payer's system
PC005	Line Counter	Text	4	Line number for this service The line counter begins with 1 and is incremented by 1 for each additional service line of a claim
PC006	Insured Group Number	Text	50	Group or policy number (not the number that uniquely identifies the subscriber)
PC007	Subscriber Social Security Number	Text	9	Subscriber's social security number. Do not include dashes. Leave blank if not available.
PC008	Plan Specific Contract Number	Text	50	Plan assigned contract number. Leave blank if Plan Specific Contract Number is subscriber's social security number. If this is a Medicaid claim, provide Medicaid ID.
PC009	Member Suffix or Sequence Number	Text	20	Uniquely identifies the member within the contract
PC010	Member Social Security Number	Text	9	Member's social security number. Do not include dashes. Leave blank if not available.
PC011	Individual Relationship Code	Text	2	See Table 4010.6 (b) Relationship Codes
PC012	Member Gender	Text	1	M Male
				F Female
				U Unknown
				O Other
PC013	Member Date of Birth	Date	8	
PC014	Member City Name of Residence	Text	30	City name of member
PC015	Member State	Text	2	As defined by the US Postal Service

Table 4010.03 (d) Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
PC016	Member ZIP Code	Text	9	ZIP Code of member – may include non- US codes. Do not include dash.
PC017	Paid Date (AP Date)	Date	8	Paid date or the Pharmacy Benefits Manager's billing date
PC018	Pharmacy Number	Text	30	Payer assigned pharmacy number. AHFS number is acceptable
PC019	Pharmacy Tax ID Number	Text	10	Federal taxpayer's identification number *(Please provide the pharmacy chain's federal tax identification number, if the individual retail pharmacy's tax ID# is not available.)*
PC020	Pharmacy Name	Text	30	Name of pharmacy
PC021	National Pharmacy ID Number	Text	20	Required if National Provider ID is mandated for use under HIPAA
PC022	Pharmacy Location City	Text	30	City name of pharmacy
PC023	Pharmacy Location State	Text	2	As defined by the US Postal Service
PC024	Pharmacy ZIP Code	Text	9	ZIP Code of pharmacy - may include non- US codes. Do not include dash
PC024A	Pharmacy Country Name	Text	30	Code US
PC025	Service Line Status	Text	2	See Table 4010.6 (h) Claim Status
PC026	Drug Code	Text	11	NDC Code in CMS configuration with leading zeros and no hyphens.
PC027	Drug Name	Text	80	Text name of drug
PC028	New Prescription	Number	2 (0)	00 New prescription. 01-99 Number of refill(s)
PC029	Generic Drug Indicator	Text	2	01 No, branded drug
				02 Yes, generic drug
PC030	Dispense as Written Code	Text	1	0 Not dispensed as written
				1 Physician dispense as written
				2 Member dispense as written
				3 Pharmacy dispense as written
				4 No generic available
				5 Brand dispensed as generic
				6 Override

Table 4010.03 (d) Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				7 Substitution not allowed - brand drug mandated by law
				8 Substitution allowed - generic drug not available in marketplace
				9 Other
PC031	Compound Drug Indicator	Text	1	N Non-compound drug
				Y Compound drug
				U Non-specified drug compound
PC032	Date Prescription Filled	Date	8	
PC033	Quantity Dispensed	Number	10	Number of metric units of medication dispensed
PC034	Days' Supply	Number	3	Estimated number of days the prescription will last
PC035	Charge Amount	Number	10 (2)	The full, undiscounted total and service-specific charges billed by the provider.
PC036	Paid Amount	Number	10 (2)	Includes any withhold amounts.
PC037	Ingredient Cost/List Price	Number	10 (2)	Cost of the drug dispensed. Do not code decimal point
PC038	Postage Amount Claimed	Number	10 (2)	Postage amount in dollars
PC039	Dispensing Fee	Number	10 (2)	Dispensing fess in dollars
PC040	Copay Amount	Number	10 (2)	The preset, fixed dollar amount for which the individual is responsible.
PC041	Coinsurance Amount	Number	10 (2)	Coinsurance amount in dollars
PC042	Deductible Amount	Number	10 (2)	Deductible amount in dollars
PC043	Prescription Number	Text	20	The number generated by the pharmacy when a new prescription is ordered for a person - a unique code assigned to a person's prescribed medicine
PC044	Prescribing Physician First Name	Text	35	Physician first name
PC045	Prescribing Physician Middle Name	Text	25	Physician middle name
PC046	Prescribing Physician Last Name	Text	60	Physician last name
PC047	Prescribing Physician Number	Text	20	Provider NPI

Table 4010.03 (d) Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
PC101	Subscriber Last Name	Text	60	
PC102	Subscriber First Name	Text	35	
PC103	Subscriber Middle Initial	Text	1	
PC104	Member Last Name	Text	60	
PC105	Member First Name	Text	35	
PC106	Member Middle Initial	Text	1	
PC203	Carrier Associated with Claim	Text	8	For each claim, the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
PC204	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	Text	128	For each claim, the carrier specific contract number or subscriber/member social security number when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
PC211	Cross Reference Claims ID	Text	35	The original Payer Claim Control Number (PC004). Used when a new Payer Claim Control Number is assigned to an adjusted claim.
PC212	Allowed amount	Number	10 (2)	Report the maximum amount contractually allowed for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider.
PC213	HIOS Plan ID	Text	16	The 16 character HIOS Plan ID (Standard component). Including a five digit issuer ID, two character state ID, three digit product number, four digit standard component number and two digit variant component ID. This field may not be available for all market segments; Leave blank if not available
PC214	Claim Processing Level Indicator	Text	1	1 Claim Level

Table 4010.03 (d) Pharmacy Claims Detailed File Specification				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				2 Service Line level
PC215	Service Line Type	Text	1	Report the code that defines the claim line status in terms of adjudication
				O Original
				V Void
				R Replacement
				B Back Out
				A Amendment
PC216	Denied Claim Indicator	Text	1	1 Fully Paid – the entire claim was paid at the allowed amount
				2 Partially denied – some of the claims lines were paid at the allowed amount
				3 Encounter claim – this claim records a service provided that is paid under a non FFS payment arrangement such as capitation
				4 No payment – no payment made for reasons other than non FFS payment arrangement
PC217	Denial Reason	Text	4	Denial reason code. Required when denied claim indicator = 2 or 4 NCPDP denial reason codes and CARC/RARC code list accepted, available at http://www.wpc-edi.com/reference/codelists/healthcare/health-care-services-decision-reason-codes/
PC899	Record Type	Text	2	PC
PC900	Mail Order Pharmacy Indicator	Text	1	A yes/no indicator that specifies that the pharmacy is a mail order pharmacy. Valid codes: Y=Yes, N=No
PC901	In Network Indicator	Text	1	A yes/no indicator that specifies that the provider(not the benefit) is within the health plan network. Valid codes: Y=Yes, N=No
PC902	Version Number	Number	4(0)	Version number of this claim. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line

Ins 4010.04 Dental Claims Data Tables.

(a) Dental Claims Mapping and Format Information. Use Table 4010.7 (d) to determine dental claims file mapping and formatting.

(b) Dental Claims File Header Record Layout

Table 4010.04 (b) Dental Claims Header File Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
HD001	Record Type	Text	2	HD
HD002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
HD003	National Plan ID	Text	30	CMS National Plan ID
HD004	Type of File	Text	2	DC Dental Claims
HD005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
HD006	Period Ending Date	Date	8	End of paid period for claims or end of month covered for eligibility
HD007	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

(c) Dental Claims File Trailer Record Layout

Table 4010.04 (c) Dental Claims Trailer File Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
TR001	Record Type	Text	2	TR
TR002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
TR003	National Plan ID	Text	30	CMS National Plan ID
TR004	Type of File	Text	2	DC Dental Claims
TR005	Period Beginning Date	Date	8	Beginning of paid period for claims or beginning of month covered for eligibility
TR006	Period Ending Date	Date	8	End of paid period for claims or beginning of month covered for eligibility
TR007	Extraction Date	Date	8	Date file was created
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file

(d) Dental Claims Detailed File Specifications

Table 4010.04 (d) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
DC001	Payer	Text	8	Payer submitting payments
DC002	National Plan ID	Text	30	CMS National Plan ID
DC003	Insurance Type/Product Code	Text	2	As established by X12 Accredited Standards Committee, available at https://ushik.ahrq.gov/ViewItemDetails?system=sdo&itemKey=133161000
DC004	Payer Claim Control Number	Text	35	Must apply to entire claim and be unique within payer's system
DC005	Line Counter	Text	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim
DC006	Insured Group or Policy Number	Text	50	Group or policy number (not the number that uniquely identifies the subscriber)
DC007	Subscriber Social Security Number	Text	9	Subscriber's social security number. Do not include dashes. Leave blank if not available.
DC008	Plan Specific Contract Number	Text	50	Plan assigned contract number. Leave blank if Plan Specific Contract Number is subscriber's social security number. If this is a Medicaid claim, provide Medicaid ID.
DC009	Member Suffix or Sequence Number	Text	20	Uniquely identifies the member within the contract
DC010	Member Social Security Number	Text	9	Member's social security number. Do not include dashes. Leave blank if not available.
DC011	Individual Relationship Code	Text	2	See Table 4010.6 (b) Relationship Codes
DC012	Member Gender	Text	1	M Male
				F Female
				U Unknown
				O Other
DC013	Member Date of Birth	Date	8	
DC014	Member City Name	Text	30	City name of member
DC015	Member State or Province	Text	2	As defined by the U.S. Postal Service
DC016	Member ZIP Code	Text	9	ZIP Code of member – may include non- US codes. Do not include dash.
DC017	Paid Date/AP Date	Date	8	

Table 4010.04 (d) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
DC018	Service Provider Number	Text	30	Payer assigned provider number
DC019	Service Provider Tax ID Number	Text	10	Federal taxpayer's identification number – if the tax id is a provider's social security number use 'SSN' and 'NA' if unavailable
DC020	National Service Provider ID	Text	20	Required if National Provider ID is mandated for use under HIPAA
DC021	Service Provider Entity Type Qualifier	Text	1	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as "Person".
				1 Person
				2 Non-Person Entity
DC022	Service Provider First Name	Text	35	Individual first name. Leave blank if provider is a facility or organization
DC023	Service Provider Middle Name	Text	25	Individual middle name or initial. Leave blank if provider is a facility or organization
DC024	Servicing Provider Last Name or Organization Name	Text	60	Report the name of the organization or last name of the individual provider. DC021 determines if this is an Organization or Individual Name reported here.
DC025	Service Provider Suffix	Text	10	Suffix to individual name. Leave blank if provider is a facility or organization
DC026	Service Provider Specialty	Text	10	National Uniform Claims Committee (NUCC) standard code that defines this provider for this line of service. Dictionary for specialty code values must be supplied during testing.
DC027	Service Provider City Name	Text	30	City name of provider - practice location
DC028	Service Provider State or Province	Text	2	As defined by the U.S. Postal Service
DC029	Service Provider ZIP Code	Text	9	ZIP Code of provider - may include non-US codes.
DC030	Place of Service - Professional	Text	2	See Table 4010.6 (g) Place of Service -- Professional

Table 4010.04 (d) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
DC031	Claim Status	Text	2	See Table 4010.6 (h) Claim Status
DC032	CDT Code	Text	5	Common Dental Terminology code
DC033	Procedure Modifier - 1	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
DC034	Procedure Modifier - 2	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
DC035	Date of Service - From	Date	8	First date of service for this service line.
DC036	Date of Service - Thru	Date	8	Last date of service for this service line.
DC037	Charge Amount	Number	10 (2)	The full, undiscounted total and service-specific charges billed by the provider.
DC038	Paid Amount	Number	10 (2)	Includes any withhold amounts.
DC039	Copay Amount	Number	10 (2)	The present, fixed dollar amount for which the individual is responsible.
DC040	Coinsurance Amount	Number	10 (2)	The dollar amount an individual is responsible for - not the percentage.
DC041	Deductible Amount	Number	10 (2)	Deductible amount in dollars
DC042	Billing Provider Number	Text	30	Carriers, third-party administrators, and dental claims processors shall code using the payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change
DC043	National Billing Provider Number ID	Text	30	This is the NPI for the billing provider
DC044	Billing Provider Last Name	Text	60	Full name of provider billing organization or last name of individual billing provider.
DC101	Subscriber Last Name	Text	60	
DC102	Subscriber First Name	Text	35	
DC103	Subscriber Middle Initial	Text	1	
DC104	Member Last Name	Text	60	
DC105	Member First Name	Text	35	

Table 4010.04 (d) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
DC106	Member Middle Initial	Text	1	
DC201	Carrier Associated with Claim	Text	8	For each claim, the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all dental claims processed by a TPA under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
DC202	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	Text	128	For each claim, the carrier specific contract number or subscriber/member social security number when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files.
DC203	Practitioner Group Practice	Text	60	Name of group practice to which a practitioner is affiliated if different from DC044.
DC204	Tooth Number/Letter	Text	2	Report the tooth identifier(s) when DC032 is within the given range. Required when DC032 = D2000 thru D2999
DC205	Dental Quadrant	Text	2	Standard quadrant identifier from the External Code Source referenced in Ins 4009.05. Provides further detail on procedure(s)
DC206	Tooth Surface	Text	5	Tooth surface(s) that this service relates to. Provides further detail on procedure
DC207	Claim Version	Text	4	Version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters.
DC208	Diagnosis Code	Text	7	ICD CM Diagnosis Code when applicable
DC209	ICD Indicator	Text	1	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10.
				0 ICD-9
				1 ICD-10
DC211	Cross Reference Claims ID	Text	35	The original Payer Claim Control Number (DC004). Used when a new Payer Claim Control Number is assigned to an adjusted claim.
DC212	Allowed amount	Number	10 (0)	Report the maximum amount contractually allowed and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider

Table 4010.04 (d) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				contract and most often it is less than or equal to the fee charged by the provider. Shall be reported even when paid amount = 0 but member receives care. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070
DC213	HIOS Plan ID	Text	16	The 16 character HIOS Plan ID (Standard component). Including a five digit issuer ID, two character state ID, three digit product number, four digit standard component number and two digit variant component ID. This field may not be available for all market segments; Leave blank where not available
DC215	Service Line Type	Text	1	Report the code that defines the claim line status in terms of adjudication
				O Original
				V Void
				R Replacement
				B Back Out
				A Amendment
DC218	Claim Processing Level Indicator	Text	1	1 Claim Level
				2 Service Line level
DC219	Denied Claim Indicator	Text	1	1 Fully Paid – the entire claim was paid at the allowed amount
				2 Partially denied – some of the claims lines were paid at the allowed amount
				3 Encounter claim – this claim records a service provided that is paid under a non FFS payment arrangement such as capitation
				4 No payment – no payment made for reasons other than non FFS payment arrangement
DC220	Denial Reason	Text	4	Denial reason code. Required when denied claim indicator = 2 or 4 http://www.wpc-edi.com/reference/

Table 4010.04 (d) Dental Claims Detailed File Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
DC899	Record Type	Text	2	DC
DC900	In Network Indicator	Text	1	A yes/no indicator that specifies that the provider (not the benefit) is within the health plan network. Valid codes: Y=Yes, N=No
DC901	Quantity	Number	12(0)	Count of services performed

Ins 4010.05 Provider File Data Tables.

(a) Provider File Header Record Layout

Table 4010.05 (a) Provider File Header Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
HD001	Record Type	Text	2	HD
HD002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
HD003	National Plan ID	Text	30	CMS National Plan ID
HD004	Type of File	Text	2	MP Provider File
HD005	Period Beginning Date	Date	8	Beginning of span of coverage period
HD006	Period Ending Date	date	8	End of span of coverage period
HD008	Comments	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

(b) Provider File Trailer Record Layout

Table 4010.05 (b) Provider File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
TR001	Record Type	Text	2	TR
TR002	Payer	Text	8	Payer submitting payments. NHID Submitter Code
TR003	National Plan ID	Text	30	CMS National Plan ID

Table 4010.05 (b) Provider File Trailer Record Layout				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
TR004	Type of File	Text	2	MP Provider File
TR005	Period Beginning Date	Date	8	Beginning of span of coverage period
TR006	Period Ending Date	Date	8	End of span of coverage period
TR007	Extraction Date	Date	8	Date file was created
TR008	Record Count	Number	10 (0)	Total number of records submitted in this file

(c) Provider File Detailed Specifications

Table 4010.05 (c) Provider File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MP001	Payer	Text	8	Payer submitting payments. NHID Submitter Code
MP002	Plan ID	Text	30	CMS National Plan ID or NAIC code.
MP003	Provider ID	Text	30	Unique identified for the provider as assigned by the reporting entity
MP004	Provider Tax ID	Text	10	Federal taxpayer's identification number –if the tax id is a provider's social security number use 'SSN' and 'NA' if unavailable. Do not code punctuation.
MP005	Provider Entity	Text	1	Specify the value that defines the type of entity
				1 Person; physician, clinician, orthodontist, and any individual that is licensed/certified to perform health care services.
				2 Facility; hospital, health center, long term care, rehabilitation and any building that is licensed to transact health care services.
				3 Professional Group; collection of licensed/certified health care professionals that are practicing health care services under the same entity name and Federal Tax Identification Number.
				4 Retail Site; brick-and-mortar licensed/certified place of transaction that is not solely a health care entity, i.e., pharmacies, independent laboratories, vision services.
				5 E-Site; internet-based order/logistic system of health care services, typically in the form of durable medical equipment, pharmacy or vision services. Address assigned should be the address of the company delivering services or order fulfillment.

Table 4010.05 (c) Provider File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
				6 Financial Parent; financial governing body that does not perform health care services itself but directs and finances health care service entities, usually through a Board of Directors.
				7 Transportation; any form of transport that conveys a patient to/from a healthcare provider.
				8 Other; any type of entity not otherwise defined that performs health care services.
MP006	Provider First Name	Text	35	Individual first name. Leave blank if provider is a facility or organization
MP007	Provider Middle Name or Initial	Text	25	
MP008	Provider Last Name or Organization Name	Text	60	Full name of provider organization or last name of individual provider
MP009	Provider Suffix	Text	10	Example: Jr; Set as leave blank if provider is an organization. Do not use credentials such as MD or PhD
MP010	Provider Specialty	Text	10	Report the HIPAA-compliant health care provider taxonomy code. Code set is available at the National Uniform Claims Committee's web site at http://www.nucc.org/
MP011	Provider Office Street Address	Text	50	Physical address – address where provider delivers health care services
MP012	Provider Office City	Text	30	Physical address – address where provider delivers health care services
MP013	Provider Office State	Text	2	Physical address – address where provider delivers health care services. Use postal service standard 2 letter abbreviations
MP014	Provider Office Zip	Text	9	Physical address – address where provider delivers health care services. Minimum 5 digit code. Do not include dashes
MP015	Provider DEA Number	Text	12	
MP016	Provider NPI	Text	20	
MP017	Provider State License Number	Text	30	

Table 4010.05 (c) Provider File Detailed Specifications				
Data Element #	**Element**	**Type**	**Length (decimal places)**	**Description/Codes/Sources**
MP018	Entity Code	Text	2	Enter the value that defines the entity provider type. Required when MP005 does not = 1
				1 Academic Institution
				2 Adult Foster Care
				3 Ambulance Services
				4 Hospital Based Clinic
				5 Stand-Alone, Walk-In/Urgent Care Clinic
				6 Other Clinic
				7 Community Health Center - General
				8 Community Health Center - Urgent Care
				9 Government Agency
				10 Health Care Corporation
				11 Home Health Agency
				12 Acute Hospital
				13 Chronic Hospital
				14 Rehabilitation Hospital
				15 Psychiatric Hospital
				16 DPH Hospital
				17 State Hospital
				21 Licensed Hospital Satellite Emergency Facility
				22 Hospital Emergency Center
				23 Nursing Home
				24 Pharmacy
MP899	Record Type	Text	2	MP

Ins 4010.06 Data Submission Manual Code Tables.

(a) Insurance Type/Product Code – Eligibility File

Table 4010.06 (a) Insurance Type/Product Code-Eligibility File	
Code	**Description**
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-Fault Insurance including Insurance in which Auto Is Primary
15	Medicare Secondary Workers' Compensation
16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
17	Dental
18	Vision
19	Prescription Drugs
41	Medicare Secondary Black Lung
42	Medicare Secondary Veterans' Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
AP	Auto Insurance Policy
C1	Commercial
CO	Consolidated Omnibus Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
E	Medicare – Point of Service (POS)
EP	Exclusive Provider Organization
FI	Federal Employees Health Benefits Program
FF	Family or Friends
HM	Health Maintenance Organization (HMO)

Table 4010.06 (a) Insurance Type/Product Code-Eligibility File	
Code	**Description**
HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MD	Medicare Part D
MH	Medigap Part A
MI	Medigap Part B
MP	Medicare Primary
OT	Other
PE	Property Insurance – Personal
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance – Real
SP	Supplemental Policy
TF	Tax Equity Fiscal Responsibility Act (TEFRA)

Table 4010.06 (a) Insurance Type/Product Code-Eligibility File	
Code	**Description**
TR	Tricare
U	Multiple Options Health Plan
VA	Veterans Administration Plan
WU	Wrap Up Policy

(b) Relationship Codes

Table 4010.06 (b) Relationship Codes	
Code	**Description**
01	Spouse
02	Son or daughter
03	Father or Mother
04	Grandfather or Grandmother
05	Grandson or Granddaughter
06	Uncle or Aunt
07	Nephew or Niece
08	Cousin
09	Adopted Child
10	Foster Child
11	Son-in-Law or Daughter-in-Law
12	Brother-in-Law or Sister-in-Law
13	Mother-in-Law or Sister-in-Law
14	Brother or Sister
15	Ward

Table 4010.06 (b) Relationship Codes	
Code	**Description**
16	Stepparent
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee/Self
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
25	Ex-spouse
26	Guardian
27	Student
28	Friend
29	Significant Other
30	Both Parents
31	Court Appointed Guardian
32	Mother
33	Father
34	Other Adult
36	Emancipated Minor
37	Agency Representative
38	Collateral Dependent
39	Organ Donor

Table 4010.06 (b) Relationship Codes	
Code	**Description**
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner
76	Dependent

(c) Race 1/Race 2

Table 4010.06 (c) Race 1/Race 2	
Code	**Description**
R1	American Indian/Alaska Native
R2	Asian
R3	Black/African American
R4	Native Hawaiian or Other Pacific Islander
R5	White
R9	Other Race
UNKOW	Unknown/Not Specified

(d) Ethnicity 1/ Ethnicity 2

Table 4010.06 (d) Ethnicity 1/Ethnicity 2	
Code	**Description**
2182-4	Cuban
2184-0	Dominican
2148-5	Mexican, Mexican American, Chicano
2180-8	Puerto Rican

Table 4010.06 (d) Ethnicity 1/Ethnicity 2	
Code	**Description**
2161-8	Salvadoran
2155-0	Central American (not otherwise specified)
2165-9	South American (not otherwise specified)
2060-2	African
2058-6	African American
AMERCN	American
2028-9	Asian
2029-7	Asian Indian
BRAZIL	Brazilian
2033-9	Cambodian
CVERDN	Cape Verdean
CARIBI	Caribbean Island
2034-7	Chinese
2169-1	Columbian
2108-9	European
2036-2	Filipino
2157-6	Guatemalan
2071-9	Haitian
2158-4	Honduran
2039-6	Japanese
2040-4	Korean
2041-2	Laotian
2118-8	Middle Eastern

Table 4010.06 (d) Ethnicity 1/Ethnicity 2	
Code	**Description**
PORTUG	Portuguese
RUSSIA	Russian
EASTEU	Eastern European
2047-9	Vietnamese
OTHER	Other Ethnicity
UNKNOW	Unknown/Not Specified

(e) Insurance Type/Product Code – Claims Files

Table 4010.06 (e) Insurance Type/Product Code – Claims Files	
Code	**Description**
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Advantage/Risk
17	Dental Maintenance Organization
AM	Automobile Medical
CH	Champus
DS	Disability
FI	Federal Employees Health Benefits Program
HM	Health Maintenance Organization
LI	Liability

LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MD	Medicare Part D
OF	Other Federal Program (e.g., Black Lung)
SP	Supplemental Policy
TR	Tricare
TV	Title V
VA	Veterans Administration Plan
WC	Workers' Comp
ZZ	Mutually Defined (Use code ZZ when Type of Insurance is Unknown)

(f) Discharge Status

Table 4010.06 (f) Discharge Status	
Code	**Description**
01	Discharged to home or self-care
02	Discharged/transferred to another short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to a facility that provides custodial or supportive care
05	Discharged/transferred to a designated cancer center of children's hospital
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Reserved for assignment by the NUBC
09	Admitted as an inpatient to this hospital

Table 4010.06 (f) Discharge Status	
Code	**Description**
20	Expired
21	Discharged/transferred to court/law enforcement
30	Still patient or expected to return for outpatient services
40	Expired at home
41	Expired in a medical facility
42	Expired, place unknown
43	Discharged/ transferred to a Federal Hospital
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63	Discharged/transferred to a long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a critical access hospital (CAH)
69	Discharged/transferred to a designated disaster alternative care site (effective 10/1/13)
70	Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list
81	Discharged to home or self-care with a planned acute care hospital inpatient readmission (effective 10/1/13)
82	Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission (effective 10/1/13)

Table 4010.06 (f) Discharge Status	
Code	**Description**
83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (effective 10/1/13)
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (effective 10/1/13)
85	Discharged/transferred to designated cancer center of children's hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (effective 10/1/13)
87	Discharged/transferred to court / law enforcement with a planned acute care hospital inpatient readmission (effective 10/1/13)
88	Discharged/transferred to a federal healthcare facility with a planned acute care hospital inpatient readmission (effective 10/1/13)
89	Discharged/transferred to a hospital - based Medicare approved swing bed with a planned acute care hospital inpatient readmission (effective 10/1/13)
90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
91	Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)
93	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
95	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)

(g) Place of Service – Professional

Table 4010.06 (g) Place of Service -- Professional	
Code	**Description**
01	Pharmacy
02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
09	Prison/Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility Congregate
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital

Table 4010.06 (g) Place of Service -- Professional	
Code	**Description**
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance – Land
42	Ambulance – Air or Water
43-48	Unassigned
50	Federally Qualified Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center

Table 4010.06 (g) Place of Service -- Professional	
Code	**Description**
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End Stage Renal Disease Treatment Facility
66-70	Unassigned
71	State or Local Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Unlisted Facility

(h) Claim Status

Table 4010.06 (h) Claim Status	
Code	**Description**
01	Processed as primary
02	Processed as secondary
03	Processed as tertiary
04	Denied
06	Approved as amended
19	Processed as primary, forwarded to additional payer(s)
21	Processed as tertiary, forwarded to additional payer(s)
22	Reversal of previous payment

Table 4010.06 (h) Claim Status	
Code	**Description**
26	Documentation Claim - No Payment Associated
28	Repriced

(i) MC021 Point of Origin Codes

(1) If MC020 = 4 (Newborn), then use the following values at MC021:

Table 4010.06 (i) (1) MC021 Point of Origin Codes	
Code	**Description**
5	Born Inside the Hospital
6	Born Outside the Hospital

(2) For all other values at MC020, use the following table for MC021:

Table 4010.06 (i) (2) Point of Origin Codes	
Code	**Description**
1	Non-Healthcare Facility Point of Origin (Physician Referral)
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital (Different Facility)
5	Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Reserved for National Assignment

Table 4010.06 (i) (2) Point of Origin Codes	
Code	**Description**
B	Transfer from Another Home Health Agency(Discontinued July 1,2010)
C	Readmission to Same Home Health Agency (Discontinued July 1,2010)
D	Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer
E	Transfer from Ambulatory Surgical Center
F	Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in Hospice Program

Ins 4010.07 Mapping and Format Information Tables.

(a) Member Eligibility File Mapping and Format Information

Table 4010.07 (a) Member Eligibility File Mapping and Format Information		
Data Element #	**Element**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
ME001	Payer	N/A
ME002	National Plan ID	271/2100A/NM1/XV/09
ME003	Insurance Type Code/Product	271/2110C/EB/ /04, 271/2110D/EB/ /04
ME004	Year	N/A
ME005	Month	N/A
ME006	Insured Group or Policy Number	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02
ME007	Coverage Level Code	271/2110C/EB/ /03, 271/2100D/EB/ /03
ME008	Subscriber Social Security Number	271/2100C/NM1/MI/09
ME009	Plan Specific Contract Number	271/2100C/NM1/MI/09
ME010	Member Suffix or Sequence Number	N/A
ME011	Member Social Security Number	271/2100C/MN1/MI/09, 271/2100D/NM1/MI/09
ME012	Individual Relationship Code	271/2100C/INS/Y/02, 271/2100D/INS/N/02
ME013	Member Gender	271/2100C/DMG/ /03, 271/2100D/DMG/ /03
ME014	Member Date of Birth	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02

Table 4010.07 (a) Member Eligibility File Mapping and Format Information		
Data Element #	**Element**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
ME015	Member City Name	271/2100C/N4/ /01, 271/2100D/N4/ /01
ME016	Member State or Province	217/2100C/N4/ /02, 271/2100D/N4/ /02
ME017	Member ZIP Code	271/2100C/N4/ /03, 271/2100D/N4/ /03
ME018	Medical Coverage	N/A
ME019	Prescription Drug Coverage	N/A
ME020	Dental Coverage	N/A
ME021	Race 1	N/A
ME022	Race 2	N/A
ME023	Place holder	N/A
ME024	Hispanic Indicator	N/A
ME025	Ethnicity 1	N/A
ME026	Ethnicity 2	N/A
ME027	Place holder	N/A
ME028	Primary Insurance Indicator	N/A
ME029	Coverage Type	N/A
ME030	Market Category	N/A
ME031	NH Health Protection Program	N/A
ME032	Group Name	N/A
ME101	Subscriber Last Name	270/2100C/NM1/IL/1/3
ME102	Subscriber First Name	270/2100C/NM1/IL/1/4
ME103	Subscriber Middle Initial	270/2100C/NM1/IL/1/5
ME104	Member Last Name	270/2100D/NM1/QC/1/3
ME105	Member First Name	270/2100D/NM1/QC/1/4
ME106	Member Middle Initial	270/2100D/NM1/QC/1/5
		271/2100/N3//01, 02 271/2100D/N3/ /01, 02
ME203	Member’s Assigned PCP	Loop 2000B SBR02 = 18 - ELSE - Loop
ME204	HIOS Plan ID	N/A
ME205	Plan Effective Date	N/A
ME206	Minimum Value	2010CA Segment N301

Table 4010.07 (a) Member Eligibility File Mapping and Format Information		
Data Element #	**Element**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
ME207	Exchange Indicator	N/A
ME208	High Deductible Health Plan	N/A
ME209	Active Enrollment	N/A
ME210	New Coverage	N/A
ME211		N/A
ME899	Record Type	N/A
ME900	Plan State	N/A
ME901	Premium Tax Credit	N/A
ME902	NAIC Number	N/A
ME903	Grandfather Plan Indicator	N/A

(b) Medical Claims File Mapping and Format Information

Table 4010.07 (b) Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-92 Form Locator**	**UB-92 (Version 6.0) Record Type/ Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
MC001	Payer	N/A	N/A	N/A	N/A	N/A
MC002	National Plan ID	N/A	N/A	N/A	N/A	835/1000A/N1/XV/04
MC003	Product/Claim Filing Indicator Code	N/A	30/4	N/A	N/A	835/2100/CLP/ /06
MC004	Payer Claim Control Number	N/A	N/A	N/A	FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0,	835/2100/CLP/ /07

Table 4010.07 (b) Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-92 Form Locator**	**UB-92 (Version 6.0) Record Type/ Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
					GU0-02.0	
MC005	Line Counter	N/A	N/A	N/A	N/A	837/2400/LX/ /01
MC005A	Version Number	N/A	N/A	N/A	N/A	N/A
MC006	Insured Group or Policy Number	62 (A-C)	30/10	11C	DA0-10.0	837/2000B/SBR/ /03
MC007	Subscriber Social Security Number	N/A	N/A	N/A	N/A	835/2100/NM1/34/08
MC008	Plan Specific Contract Number	N/A	N/A	N/A	N/A	835/2100/NM1/HN/08
MC009	Member Suffix or Sequence Number	N/A	N/A	N/A	N/A	N/A
MC010	Member Social Security Number	N/A	N/A	N/A	N/A	835/2100/NM1/34/08
MC011	Individual Relationship Code	59 (A-C)	30/18	6	DA0-17.0	8 837/2000B/SBR/ /02, 837/2000C/PAT/ /01
MC012	Member Gender	15	20/7	3	CA0-09.0	837/2010CA/DMG/03
MC013	Member Date of Birth	14	20/8	3	CA0-08.0	837/2010CA/DMG/D8/02
MC014	Member City Name	13	20/14	5	CA0-13.0	837/2010CA/N4/ /01
MC015	Member State or Province	13	20/15	5	CA0-14.0	837/2010CA/N4/ /02
MC016	Member ZIP Code	13	20/16	5	CA0-15.0	837/2010CA/N4/ /03
MC017	Paid Date (AP Date)	N/A	N/A	N/A	N/A	N/A
MC018	Admission Date	17	20/17	N/A	N/A	837/2300/DTP/435/03
MC019	Admission Hour	18	20/18	N/A	N/A	837/2300/DTP/435/03
MC020	Admission Type	19	20/10	N/A	N/A	837/2300/CL1/ /01
MC021	Admission Source	20	20/11		N/A	837/2300/CL1/ /02
MC022	Discharge Hour	21	20/22		N/A	837/2300/DTP/096/03
MC023	Discharge Status	22	20/21	N/A	N/A	837/2300/CL1/ /03
MC024	Service Provider Number	N/A	N/A	N/A	N/A	N/A

Table 4010.07 (b) Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-92 Form Locator**	**UB-92 (Version 6.0) Record Type/ Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
MC025	Service Provider Tax ID Number	5	10/4-5	25	BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0,BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0,BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0	835/2100/NM1/FI/09
MC026	National Service Provider ID	N/A	10/6	N/A	N/A	835/2100/NM1/XX/09
MC027	Service Provider Entity Type Qualifier	N/A	N/A	N/A	N/A	835/2100/NM1/82/02
MC028	Service Provider First Name	1	10/12	33	BA0-20.0	835/2100/NM1/82/04
MC029	Service Provider Middle Name	1	10/12	33	BA0-21.0	835/2100/NM1/82/05
MC030	Service Provider Last Name or Organization Name	1	10/12	33	BA0-18.0, BA0-19.0	835/2100/NM1/82/03
MC031	Service Provider Suffix	1	10/12	33	BA0-22.0	835/2100/NM1/82/07
MC032	Service Provider Specialty	N/A	N/A	N/A	N/A	837/2000A/PRV/ZZ/03

Table 4010.07 (b) Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-92 Form Locator**	**UB-92 (Version 6.0) Record Type/ Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
MC033	Service Provider City Name	1	10/14	N/A	BA1-09.0, 15.0	837/2010A/N4/ /01
MC034	Service Provider State or Province	1	10/15	N/A	BA1-10.0, 16.0	837/2010A/N4/ /02
MC035	Service Provider ZIP Code	1	10/16	N/A	BA1-11.0, 17.0	837/2010A/N4/ /03
MC036	Type of Bill – Institutional	4	Positions 1-2: 40/4	N/A	N/A	837/2300/CLM/ /05-1
MC037	Facility Type - Professional	N/A	N/A	N/A	FA0-07.0, GU0-0.50	835/2100/CLP/ /08
MC038	Service Line Status	N/A	N/A	N/A	N/A	835/2100/CLP/ /02
MC039	Admitting Diagnosis	76	70/25	N/A	N/A	837/2300/HI/BJ/02-2
MC040	E-Code	77	70/26	N/A	N/A	837/2300/HI/BN/03-2
MC041	Principal Diagnosis	67	70/4	21.1	EA0-32.0, GX0-31.0, GU0-12.0	837/2300/HI/BK/01-2
MC042	Other Diagnosis – 1	68	70/5	21.2	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-1
MC043	Other Diagnosis – 2	69	70/6	21.3	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-2
MC044	Other Diagnosis – 3	70	70/7	21.4	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-3
MC045	Other Diagnosis – 4	71	70/8	N/A	EA0-35.0, GX0-34.0, GU0-15.0	837/2300/HI/BF/02-4
MC046	Other Diagnosis – 5	72	70/9	N/A	N/A	837/2300/HI/BF/02-5
MC047	Other Diagnosis – 6	73	70/10	N/A	N/A	837/2300/HI/BF/02-6
MC048	Other Diagnosis – 7	74	70/11	N/A	N/A	837/2300/HI/BF/02-7

Table 4010.07 (b) Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-92 Form Locator**	**UB-92 (Version 6.0) Record Type/ Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
MC049	Other Diagnosis – 8	75	70/12	N/A	N/A	837/2300/HI/BF/02-8
MC050	Other Diagnosis – 9	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-9
MC051	Other Diagnosis –10	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-10
MC052	Other Diagnosis –11	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-11
MC053	Other Diagnosis –12	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-12
MC054	Revenue Code	42	50/5,11-13, 60/5,15-16, 61/5,15-16	N/A	N/A	835/2110/SVC/RB/01-2, 835/2110/SVC/NU/01-2
MC055	Procedure Code	44	60/6,15-16, 61/6,15-16	24.1-6 D	FA0-09.0, FB0-15.0, GU0-07.0	835/2110/SVC/HC/01-2
MC056	Procedure Modifier – 1	44	60/7,15-16, 61/7, 15-16	24.1-6 D	FA0-10.0, GU0-08.0	835/2110/SVC/HC/01-3
MC057	Procedure Modifier – 2	44	60/8,15-16, 61/8,15-16	24.1-6 D	FA0-11.0	835/2110/SVC/HC/01-3
MC058	ICD-9-CM Procedure Code	80, 81(A-E)	70/13, 15, 17, 19, 21, 23	N/A	N/A	835/2110/SVC/ID/01-2
MC059	Date of Service – From	45	61/13, 15-16, 61/13, 15-16	24.1-6 A	N/A	835/2110/DTM/150/02
MC060	Date of Service – Thru	N/A	N/A	24.1-6 A	FA0-05.0, FA0-06.0	835/2110/DTM/151/02
MC061	Quantity	46	50/7, 11-13, 60/9,15-16, 61/9,15-16	24.1-6 G	FA0-19.0, FB0-16.0	835/2110/SVC/ /05
MC062	Charge Amount	47	50/8, 11-13, 60/10, 16-16, 61/11, 15-16	24.1-6F	FA0-13.0	835/2110/SVC/ /02
MC063	Paid Amount	48	N/A	N/A	N/A	835/2110/SVC/ /03
MC064	Fee for Service Equivalent	N/A	N/A	N/A	N/A	N/A
MC065	Co-pay Amount	N/A	N/A	N/A	N/A	N/A

Table 4010.07 (b) Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-92 Form Locator**	**UB-92 (Version 6.0) Record Type/ Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
MC066	Coinsurance Amount	N/A	N/A	N/A	N/A	N/A
MC067	Deductible Amount	N/A	N/A	N/A	N/A	N/A
MC068	Patient Account/Control Number	3	N/A	N/A		837/2300/CLM/1
MC069	Discharge Date					
MC070	Service Provider Country Name	N/A	N/A	N/A	N/A	N/A
MC071	DRG	N/A	N/A	N/A	N/A	837/2300/HI/DR/2
MC072	DRG Version	N/A	N/A	N/A	N/A	N/A
MC073	APC	N/A	N/A	N/A	N/A	N/A
MC074	APC Version	N/A	N/A	N/A	N/A	N/A
MC075	Drug Code	N/A				837/2400/SV2/N1/2 837/2400/SV2/N2/2 837/2400/SV2/N3/2 837/2400/SV2/N4/2 837/2400/SV2/ND/2
MC076	Billing Provider Number	N/A	N/A	N/A	N/A	N/A
MC077	National Billing Provider Number ID	N/A	N/A	N/A	N/A	N/A
MC078	Billing Provider Organization or Last Name	N/A	N/A	N/A	N/A	N/A
MC101	Encrypted Subscriber Last Name	N/A	N/A	N/A	N/A	837/2110BA/NM1/IL/1/3
MC102	Encrypted Subscriber First Name	N/A	N/A	N/A	N/A	837/2110BA/NM1/IL/1/4

Table 4010.07 (b) Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-92 Form Locator**	**UB-92 (Version 6.0) Record Type/ Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
MC103	Encrypted Subscriber Middle Initial	N/A	N/A	N/A	N/A	837/2110BA/NM1/IL/1/5
MC104	Encrypted Member Last Name	N/A	N/A	N/A	N/A	837/2110CA/NM1/QC/1/3
MC105	Encrypted Member First Name	N/A	N/A	N/A	N/A	837/2110CA/NM1/QC/1/4
MC106	Encrypted Member Middle Initial	N/A	N/A	N/A	N/A	837/2110CA/NM1/QC/1/5
MC200	ICD Indicator	N/A	N/A	N/A	N/A	Set value here based upon Loop 2300 Segment H101-01 starting with the letter A
MC202	Other ICD-CM Procedure code - 2	N/A	N/A	N/A	N/A	837/2300 H102-1=BQ (ICD-9) or = BBQ (ICD-10)
MC203	Other ICD-CM Procedure code - 3	N/A	N/A	N/A	N/A	837/2300 H102-1=BQ (ICD-9) or = BBQ (ICD-10)
MC204	Other ICD-CM Procedure code - 4	N/A	N/A	N/A	N/A	837/2300 H102-1=BQ (ICD-9) or = BBQ (ICD-10)
MC205	Other ICD-CM Procedure code - 5	N/A	N/A	N/A	N/A	837/2300 H102-1=BQ (ICD-9) or = BBQ (ICD-10)
MC206	Other ICD-CM Procedure code - 6	N/A	N/A	N/A	N/A	837/2300 H102-1=BQ (ICD-9) or = BBQ (ICD-10)
MC207	Carrier Associated with Claim	N/A	N/A	N/A	N/A	N/A
MC208	Carrier Plan Specific contract Number or Subscriber/Member Social Security Number	N/A	N/A	N/A	N/A	N/A
MC209	Practitioner Group Practice	N/A	N/A	N/A	N/A	N/A

Table 4010.07 (b) Medical Claims File Mapping and Format Information						
Data Element #	**Data Element Name**	**UB-92 Form Locator**	**UB-92 (Version 6.0) Record Type/ Field #**	**HCFA 1500 #**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
MC210	Coordination of Benefits/Third Party Liability Amount	N/A	N/A	N/A	N/A	835/2320 AMT02
MC211	Cross Reference Claims ID	N/A	N/A	N/A	N/A	N/A
MC212	Allowed Amount	N/A	N/A	N/A	N/A	837/2300 HCP02
MC215	Service Line Type	N/A	N/A	N/A	N/A	N/A
MC216	Payment Arrangement Type	N/A	N/A	N/A	N/A	Loop 2400 Segment HCP01
MC217	Pay for Performance Flag	N/A	N/A	N/A	N/A	N/A
MC218	Claim Processing Level Indicator	N/A	N/A	N/A	N/A	N/A
MC219	Denied Claim Indicator	N/A	N/A	N/A	N/A	Loop 2430 CAS identification
MC220	Denial Reason	N/A	N/A	N/A	N/A	Loop 2430 CAS identification
MC221	Procedure Modifier – 3	N/A	N/A	N/A	N/A	837/2430 SVD03-05
MC222	Procedure Modifier – 4	N/A	N/A	N/A	N/A	837/2430 SVD03-06
MC899	Record Type	N/A	N/A	N/A	N/A	N/A
MC900	[~~HIOS Plan ID~~]***In Network Indicator***	N/A	N/A	N/A	N/A	***N/A***
MC901	[~~In Network Indicator~~]***Unit of Measure***	N/A	N/A	N/A	N/A	

(c) Pharmacy Claims File Mapping and Format Information

Table 4010.07 (c) Pharmacy Claims File Mapping and Format Information		
Data Element	**Element**	**National Council for Prescription Drug Programs Field #**
PC001	Payer	879
PC002	Plan ID	879
PC003	Insurance Type/Product Code	N/A
PC004	Payer Claim Control Number	993-A7
PC005	Line Counter	N/A
PC006	Insured Group Number	301-C1
PC007	Subscriber Social Security Number	302-C2
PC008	Plan Specific Contract Number	N/A
PC009	Member Suffix or Sequence Number	N/A
PC010	Member Identification Code	302-CY
PC011	Individual Relationship Code	306-C6
PC012	Member Gender	305-C5
PC013	Member Date of Birth	304-C4
PC014	Member City Name of Residence	323-CN
PC015	Member State or Province	324-CO
PC016	Member ZIP Code	325-CP
PC017	Paid Date (AP Date)	N/A
PC018	Pharmacy Number	202-B2
PC019	Pharmacy Tax ID Number	N/A
PC020	Pharmacy Name	833-5P
PC021	National Pharmacy ID Number	N/A
PC022	Pharmacy Location City	831-5N
PC023	Pharmacy Location State	832-6F
PC024	Pharmacy ZIP Code	835-5R
PC024A	Pharmacy Country Name	N/A
PC025	Service Line Status	N/A
PC026	Drug Code	407-D7
PC027	Drug Name	516-FG
PV028	New Prescription	403-D3
PC029	Generic Drug Indicator	N/A
PC030	Dispense as Written Code	408-D8

Table 4010.07 (c) Pharmacy Claims File Mapping and Format Information		
Data Element	**Element**	**National Council for Prescription Drug Programs Field #**
PC031	Compound Drug Indicator	406-D6
PC032	Date Prescription Filled	401-D1
PC033	Quantity Dispensed	442-E7
PC034	Days Supply	405-D5
PC035	Charge Amount	804-5B
PC036	Paid Amount	509-F9
PC037	Ingredient Cost/List Price	506-F6
PC038	Postage Amount Claimed	428-DS
PC039	Dispensing Fee	507-F7
PC040	Copay Amount	518-FI
PC041	Coinsurance Amount	518-FI
PC042	Deductible Amount	505-F5
PC043	Placeholder	N/A
PC044	Prescribing Physician First Name	717
PC045	Prescribing Physician Middle Name	N/A
PC046	Prescribing Physician Last Name	716
PC047	Prescribing Physician Number	411-DB
PC101	Subscriber Last Name	716
PC102	Subscriber First Name	717
PC103	Subscriber Middle Initial	718
PC104	Member Last Name	716
PC105	Member First Name	717
PC106	Member Middle Initial	718
PC203	Carrier Associated with Claim	N/A
PC204	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	N/A
PC211	Cross Reference Claims ID	N/A
PC212	Allowed Amount	N/A
PC213	HIOS Plan ID	N/A
PC214	Claim Processing Level Indicator	N/A
PC215	Service Line Type	N/A

Table 4010.07 (c) Pharmacy Claims File Mapping and Format Information		
Data Element	**Element**	**National Council for Prescription Drug Programs Field #**
PC216	Denied Claim Indicator	N/A
PC217	Denial Reason	N/A
PC899	Record Type	N/A
PC900	Mail Order Pharmacy Indicator	N/A
PC901	In Network Indicator	N/A
PC902	Version Number	N/A

(d) Dental Claims File Mapping and Format Information

Table 4010.07 (d) Dental Claims File Mapping and Format Information			
Data Element #	**Data Element Name**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
DC001	Payer	N/A	N/A
DC002	National Plan Id	N/A	N/A
DC003	Insurance Type/Product Code	N/A	835/2100/CLP/ /06
DC004	Payer Claim Control Number	N/A	835/2100/CLP/ /07
DC005	Line Counter	FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0GU0-02.0	837/2400/LX/ /01
DC006	Insured Group or Policy Number	DA0-10.0	837/2000B/SBR/ /03
DC007	Subscriber Social Security Number	N/A	837/2010BA/REF/SY/02
DC008	Plan Specific Contract Number	N/A	835/2100/NM1/MI/08
DC009	Member Suffix or Sequence Number	N/A	N/A
DC010	Member Social Security Number	N/A	835/2100/NM1/34/09
DC011	Individual Relationship Code	DA0-17.0	837/2000B/SBR/ /02, 837/20000C/PAT/ /01

Table 4010.07 (d) Dental Claims File Mapping and Format Information			
Data Element #	**Data Element Name**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
DC012	Member Gender	CA0-09.0	837/2010BA/DMB/ /03, 837/2010CA/DMB/ /03
DC013	Member Date of Birth	CA0-08.0	837/2010BA/DMB/D8/02, 837/2010CA/DMB/D8/02
DC014	Member City Name of Residence	CA0-13.0	837/2010BA/N4/ /01, 837/2010CA/N4/ /01
DC015	Member State or Province	CA0-14.0	837/2010BA/N4/ /02, 837/2010CA/N4/ /02
DC016	Member ZIP Code of Residence	CA0-15.0	837/2010BA/N4/ /03, 837/2010CA/N4/ /03
DC017	Date Service Approved	N/A	835/Header Financial Information/BPR/ /16
DC018	Service Provider Number	N/A	835/21000/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, 835/2100/NM1/BD/09, 835/2100/NM1/BS/09, 835/2100/NM1/MC/09, 835/2100/NM1/PC/09
DC019	Service Provider Tax ID Number	BA0-09.0, CA0-28.0, BA0-02.0,BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0,BA0-17.0, BA0-24.0, YA0-06.0	835/2100/NM1/FI/09
DC020	National Service Provider ID	N/A	837/2310B/NM1/XX/09
DC021	Service Provider Entity Type Qualifier	N/A	837/2310B/NM1/82/02
DC022	Service Provider First Name	BA0-20.0	837/2310B/NM1/82/04
DC023	Service Provider Middle Name	BA0-21.0	837/2310B/NM1/82/05

Table 4010.07 (d) Dental Claims File Mapping and Format Information			
Data Element #	**Data Element Name**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
DC024	Service Provider Last Name or Organization Name	BA0-18.0, BA0-19.0	837/2310B/NM1/82/03
DC025	Service Provider Suffix	BA0-22.0	837/2310B/NM1/82/07
DC026	Service Provider Specialty	N/A	837/2310B/PRV/PXC/03
DC027	Service Provider City name	BA1-09.0, 15.0	837/2310C/N4/ /01
DC028	Service Provider State or Province	BA1-10.0, 16.0	837/2310C /N4/ /02
DC029	Service Provider ZIP Code	BA1-11.0, 17.0	837/2310C /N4/ /03
DC030	Facility Type - Professional	FA0-07.0, GU0-0.50	837/2300/CLM/05-1
DC031	Claim Status		835/2100/CLP/ /02
DC032	CDT Code	FA0-09.0, FB0-15.0, GU0-07.0	837/2400/SV3/AD/01-2
DC033	Procedure Modifier - 1	FA0-10.0, GU0-08.0	837/2400/SV3/AD/01-3
DC034	Procedure Modifier - 2	FA0-11.0	837/2400/SV3/AD/01-4
DC035	Date of Service - From	N/A	837/2400/DTP/472/D8/03, 837/2300/DTP/472/D8/03
DC036	Date of Service - Thru	FA0-05.0, FA0-06.0	837/2400/DTP/472/D8/03, 837/2300/DTP/472/D8/03
DC037	Charge Amount	FA0-13.0	837/2400/SV3/ /02
DC038	Paid Amount	N/A	835/2110/SVC/ /03
DC039	Copay Amount	N/A	835/2110/CAS/PR/3-03
DC040	Coinsurance Amount	N/A	835/2110/CAS/PR/2-03
DC041	Deductible Amount	N/A	835/2110/CAS/PR/1-03
DC042	Billing Provider Number	N/A	837/2010BB/REF/G2/02
DC044	National Billing Provider ID	N/A	837/2010AA/NM1/XX/09
DC044	Billing Provider Last Name	N/A	837/2010AA/NM1/ /03
DC101	Subscriber Last Name	N/A	837/2010BA/NM1/ /03
DC102	Subscriber First Name	N/A	837/2010BA/NM1/ /04
DC103	Subscriber Middle Initial	N/A	837/2010BA/NM1/ /05
DC104	Member Last Name	N/A	837/2010BA/NM1/ /03, 837/2010CA/NM1/ /03
DC105	Member First Name	N/A	837/2010BA/NM1/ /04, 837/2010CA/NM1/ /04

Table 4010.07 (d) Dental Claims File Mapping and Format Information			
Data Element #	**Data Element Name**	**NSF (National Standard Format) Locator**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
DC106	Member Middle Initial	N/A	837/2010BA/NM1/ /05, 837/2010CA/NM1/ /05
DC201	Carrier Associated with Claim	N/A	N/A
DC202	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	N/A	N/A
DC203	Practitioner Group Practice	N/A	N/A
DC204	Tooth Number/Letter	N/A	837/2400 TOO02
DC205	Dental Quadrant	N/A	N/A
DC206	Tooth Surface		837/2400 TOO03
DC207	Claim Version	N/A	N/A
DC208	Diagnosis Code	N/A	837/2300 H101-2
DC209	ICD Indicator	N/A	N/A
DC211	Cross Reference Claims ID	N/A	N/A
DC212	Allowed Amount	N/A	837/2300 HCP02
DC213	HIOS Plan ID	N/A	N/A
DC215	Service Line Type	N/A	N/A
DC218	Claim Processing Level Indicator	N/A	N/A
DC219	Denied Claim Indicator	N/A	N/A
DC220	Denial Reason	N/A	N/A
DC899	Record Type	N/A	N/A
DC900	***In Network Indicator***	***N/A***	***N/A***
DC901	***Quantity***	***N/A***	***N/A***

Appendix A

RULE	STATUTE
Ins 4001.01	RSA 400-A:15, I; 420-G:14
Ins 4002.01	RSA 400-A:15, I; 420-G:14
Ins 4003.01	RSA 400-A:15, I; 420-G:14
Ins 4003.02	RSA 400-A:15, I; 420-G:14
Ins 4003.03	RSA 400-A:15, I; 420-G:14
Ins 4004.01	RSA 400-A:15, I; 420-G:14
Ins 4004.02	RSA 400-A:15, I; 420-G:14
Ins 4004.03	RSA 400-A:15, I; 420-G:14
Ins 4005.01	RSA 400-A:15, I; 420-G:14
Ins 4005.02	RSA 400-A:15, I; 420-G:14
Ins 4005.03	RSA 400-A:15, I; 420-G:11; 420-G:14
Ins 4006.01	RSA 400-A:15, I; 420-G:14
Ins 4006.02	RSA 400-A:15, I; 420-G:14
Ins 4006.03	RSA 400-A:15, I; 420-G:14
Ins 4006.04	RSA 400-A:15, I; 420-G:14
Ins 4006.05	RSA 400-A:15, I; 420-G:14
Ins 4006.06	RSA 400-A:15, I; 420-G:14
Ins 4007.01	RSA 400-A:15, I; 420-G:14
Ins 4008.01	RSA 400-A:15, I; 420-G:14
Ins 4009.01	RSA 400-A:15, I; 420-G:14; 541-A:21, VI(a)(2)
Ins 4009.02	RSA 400-A:15, I; 420-G:14; 541-A:21, VI(a)(2)
Ins 4009.03	RSA 400-A:15, I; 420-G:14; 541-A:21, VI(a)(2)
Ins 4009.04	RSA 400-A:15, I; 420-G:14; 541-A:21, VI(a)(2)
Ins 4010.01	RSA 400-A:15, I; 420-G:14; 541-A:21, VI(a)(2)
Ins 4010.02	RSA 400-A:15, I; 420-G:14; 541-A:21, VI(a)(2)
Ins 4010.03	RSA 400-A:15, I; 420-G:14; 541-A:21, VI(a)(2)
Ins 4010.04	RSA 400-A:15, I; 420-G:14; 541-A:21, VI(a)(2)
Ins 4010.05	RSA 400-A:15, I; 420-G:14; 541-A:21, VI(a)(2)
Ins 4010.06	RSA 400-A:15, I; 420-G:14; 541-A:21, VI(a)(2)
Ins 4010.07	RSA 400-A:15, I; 420-G:14; 541-A:21, VI(a)(2)

Appendix B – NHID Opt-In Form

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301
(603) 271-2261 Fax (603) 271-1406
TDD Access: Relay NH 1-800-735-2964

NHID Opt-In Form

All-Payer Claims Database Indication of Intent for Private Employers Offering Self-Funded Health Coverage in New Hampshire

You are receiving this form under a 2016 New Hampshire law allowing a self-funded private employer to direct its claims administrator to include the health care claims data of its employees and covered dependents in the state's All-Payer Claims Database (APCD) (NH RSA 420-G:11, V).

- In response to rising health care costs, the New Hampshire Insurance Department has, since 2003, collected health care claims data from insurers and third-party administrators in an APCD. To protect privacy, under state law the database "shall not include or disclose any data that contains direct personal identifiers".
  (NH RSA 420-G:11-a, I)

- The APCD enhances transparency, providing employers, policymakers, payers, and health care providers with vital information about the factors contributing to rising health care costs in New Hampshire. In addition, the Insurance Department uses the database to provide health cost information to the public, including employers and their employees, through the NH HealthCost website: http://nhhealthcost.nh.gov/.

- New Hampshire's database has always included data from self-funded employers, because the accuracy of information derived from the database increases when more claims are included. In 2016, the U.S. Supreme Court ruled that Vermont could not require self-funded private employers to submit data to the state's APCD. To clarify New Hampshire law after that ruling, the legislature required the creation of this form to allow self-funded private employers to direct their claims administrators to include their data.

If you elect to participate, please indicate your intent below by checking, signing, and providing the requested information; then return this form to your claims administrator. If you have questions about New Hampshire's APCD or the department's efforts to improve health care cost transparency, contact the NH Insurance Department at 603.271.2261 or requests@ins.nh.gov, or visit http://www.nh.gov/insurance/. Thank you.

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Please check, sign, and supply information requested below, if electing to participate:

On behalf of the Employer listed below, I elect to participate in claims data submission to the NH APCD. I direct the Third-Party Administrator listed below to submit data to the NH APCD and to disclose this election to the NH Insurance Department.

Authorizing Signature: _____

Name and Title of Person Authorizing:_____

Date of Signature: _____

Employer Name: _____

Employer Address: _____

Employer Contact Name: _____

Employer Contact Phone and Email: _____

Approximate # of enrolled lives in NH:_____

Third-Party Administrator: _____

INSTRUCTIONS FOR COMPLETING "NH Opt-In Form"

Fill in the blank next to the requested information as follows:

Authorizing Signature means the signature of the person authorized to act on behalf of the employer.

Name and Title of Person Authorizing means the printed name and title of the person signing on behalf of the employer.

Date of Signature means the date the form is signed.

Employer Name means the name of the employer being presented the form.

Employer Address means the business address of the employer.

Employer Contact Name means the name of a person, acting on behalf of the employer, that can be contacted with any questions.

Employer Contact Phone and Email means the phone number and email address of the Employer Contact person.

Approximate # of Enrolled Lives in NH means the number of enrollees in the self-funded health coverage, to the best knowledge of the authorizing person.

Third-Party Administrator means the name of the claims administrator for the Employer named on the form.

Appendix C – Incorporation by Reference

Rule	Title	Obtain
Ins 4003.01(a)	New Hampshire Comprehensive Health Care Information System (NHCHIS) Registration Form	Online for no cost at: https://nhchis.com/